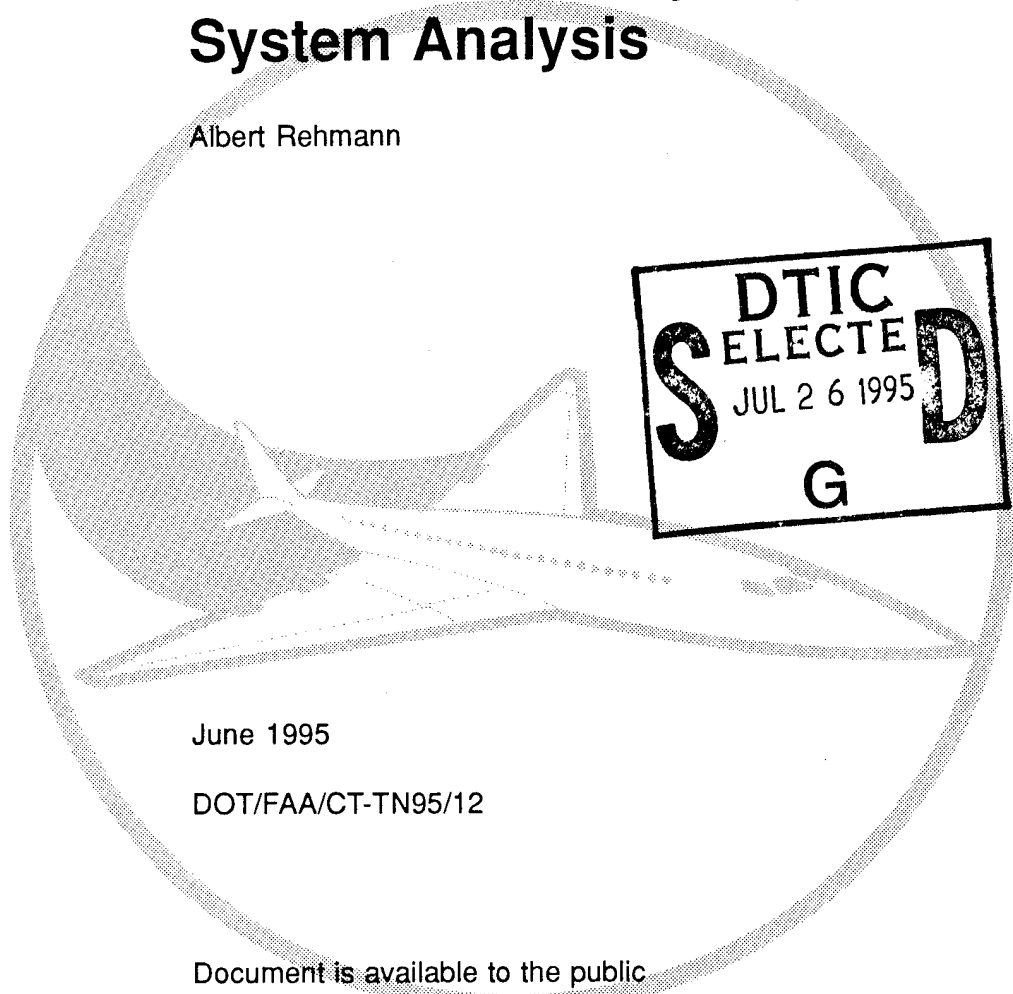


# Flightdeck Party Line Issues: An Aviation Safety Reporting System Analysis

Albert Rehmann



June 1995

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16. Abstract <p>This document describes an analysis of the Aviation Safety Reporting System (ASRS) with regards to human factors aspects concerning the implementation of data link into the flightdeck. The ASRS database contains thousands of reports concerning actual or potential deficiencies which may compromise the safety of aviation operations in the National Airspace System (NAS). The purpose of this study was to determine the relative frequency of errors and consequences of decisions based on incorrect information received from the party line.</p> <p>Detailed analysis of the reports revealed two types of errors: those attributed to incorrect transmission of party line information (14 percent error rate) and those resulting from flight crew actions/decisions based on the transmitted information (26 percent error rate). Almost half (46 percent) of the reports concerning incorrect flight crew actions were a result of executing unauthorized clearances due to similar call signs. Further analysis of the incident reports also reveals party line informational (PLI) elements that are determined useful by the flight crews. Based on the reports provided, conclusions are made with regards to the loss of the party line in a data link implementation.</p>					
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# FOREWORD

This report documents work performed by Crew System Ergonomics Information Analysis Center (CSERIAC) on subtask 3 out of three of the task entitled "Aviation Safety Reporting System Analysis." The task was a provision of an Interagency Agreement between the Federal Aviation Administration (FAA) Technical Center (Department of Transportation (DOT)) and the Defense Technical Information Center (DTIC). It was conducted under DOD Contract Number DLA900-88-D-0393, and the CSERIAC Task Number was 93956-19. The CSERIAC Program Manager was Mr. Don Dreesbach. The CSERIAC Task Leader was Mr. Michael C. Reynolds. The FAA Technical Program Manager (TPM) was Mr. Albert J. Rehmann, and the FAA project engineer was Mr. Pocholo Bravo.

Special thanks to all personnel at the Aviation Safety Reporting System (ASRS), located at National Aeronautics and Space Administration (NASA) Ames Research Center, for their cooperation.

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## TABLE OF CONTENTS

	Page
EXECUTIVE SUMMARY	vii
1. INTRODUCTION	1
1.1 General	1
1.2 Organization of the Report	1
1.3 ASRS Database	2
2. BACKGROUND	3
3. OBJECTIVE	4
4. PROCEDURE	4
5. RESULTS AND DISCUSSION	5
5.1 Classification/Definition of Data	6
5.2 Party Line Analysis	9
5.3 Further Discussion	22
6. CONCLUSIONS	23
6.1 General	23
6.2 Data link Interpretations	23
7. RECOMMENDATIONS FOR FUTURE WORK	25
8. REFERENCES	26
9. ACRONYMS AND ABBREVIATIONS	27
APPENDICES	
A PLI Element Classification Table	
B Full Form Reports	

## LIST OF ILLUSTRATIONS

Figure	Page
1 Controlling Agency	9
2 Type of Aircraft	10
3 Advisory PLI Elements	11
4 Instructional PLI Elements	12
5 Listener Actions	14
6 Error Analysis Tree	16

## LIST OF TABLES

Table	Page
1 Situational Awareness/Party Line Keyword List	5
2 Classification of Data	8
3 Source by Type	12
4 Aircraft Configuration	13
5 Listener Actions - Correct/Incorrect	14
6 Resulting Incident	15
7 Error Category Percentages	17
8 Weather Conditions	21

## EXECUTIVE SUMMARY

This document describes the third of three studies relating to the analysis of the Aviation Safety Reporting System (ASRS) with regards to human factors aspects concerning the implementation of data link into the flightdeck. The ASRS database contains thousands of reports concerning actual or potential deficiencies which may compromise the safety of aviation operations in the National Airspace System (NAS). The purpose of this study was to determine the relative frequency of errors and consequences of decisions based on incorrect information received from the party line. Further analysis of the incident reports also reveals party line informational (PLI) elements that are determined useful by the flight crews.

A list of words relating to party line and situational awareness (SA) was provided to National Aeronautics and Space Administration (NASA) Ames ASRS research analysts for the purpose of searching the database. Approximately 300 incident reports were provided by ASRS. After analysis by Crew System Ergonomics Information Analysis Center (CSERIAC), a total of 85 reports were considered relevant to the task.

Detailed analysis of the reports revealed two types of errors: (1) those attributed to incorrect transmission of party line information (14 percent error rate), and (2) those resulting from flight crew actions/decisions based on the transmitted information (26 percent error rate). Almost half (46 percent) of the reports concerning incorrect flight crew actions were a result of executing unauthorized clearances due to similar call signs.

Additional analysis yielded two types of PLI elements; instructional or advisory. Instructional elements were normally conveyed by air traffic control (ATC) and involved clearances; e.g., altitudes, headings, etc. Advisory type information was normally conveyed by other aircraft, such as position and ride reports.

The majority of reports (89 percent) were near or on the airport surface. The party line was used; e.g., to obtain useful information about landing/departing aircraft and runway/taxi instructions. Information regarding current weather conditions, such as icing, winds, and runway braking reports was also evident in the reports. Based on the reports provided, conclusions are made with regards to the loss of the party line in a data link implementation.

## 1. INTRODUCTION.

### 1.1 GENERAL.

The Aviation Safety Reporting System (ASRS) database is a convenient way to assess, from a pilot's/controller's point-of-view, the problems which exist in the National Airspace System (NAS). The information can be used; e.g., to suggest design enhancements for a variety of onboard control/display systems. This analysis identifies the advantages and disadvantages of the party line. Situational awareness contributions as a result of the party line will be the focus of this report.

According to Midkiff, et al., (1992), crews routinely listen to the party line to gain information regarding traffic around them, but rarely make decisions based on the information alone. Presently, there are systems such as the Traffic Alert and Collision Avoidance System (TCAS) that are available which aid the crew in acquiring an awareness of the current traffic situation. Crews can supplement party line information with TCAS and/or visually acquire traffic themselves prior to making decisions. Onboard weather (WX) radar devices provide current but not necessarily complete weather information. Crews utilize the party line for information regarding turbulence, icing, etc. The radio transmissions provide, in some instances, voice inflections or a sense of urgency that you could not get with a radar device.

Without the aid of other systems, such as TCAS, a concern is that pilots sometimes construct a false mental picture of what is happening. This may sometimes be provoked by false, misleading, or incomplete information or may simply be due to incorrect assumptions or interpretations of the party line. The lack of a complete picture may result in incorrect actions by the flight crew.

Therefore, the focus of this report was to ask two basic questions: (1) what information is conveyed over the party line? and, (2) what crew actions, correct or incorrect, are taken as a result of listening to the party line?

### 1.2 ORGANIZATION OF THE REPORT.

First, the report will provide a brief introduction of the ASRS reporting system (section 1.3), its history and function within the NAS. Section 3. (Objective) describes the analysis objective and section 4. (Procedure) provides a comprehensive explanation of the tasks performed to formulate this report, from the initial contact with ASRS to the receiving and analyzing of the incident reports.

Section 5. (Results and Discussion) contains the analysis and discussion of the party line informational (PLI) elements. The section is broken into three parts. The first section (5.1 Classification of Data) provides a general description of the

various categorizations of the PLI elements discovered in the analysis. The second section (5.2 Party Line Analysis) introduces various descriptive and summary statistics along with a discussion on the PLI elements. The third section (5.3 Further Discussion) provides further discussion on reported incidents that were not conducive to analysis, but were, nonetheless, considered useful to the overall discussion of the party line and the effects on the flight crew.

Section 6. (Conclusions) will provide conclusions based on the analysis of the PLI elements. Conclusions will be drawn on the problems that may arise without the party line in a data link environment. The report concludes with recommendations for future work (section 7.) to further investigate issues of the party line.

### 1.3 ASRS DATABASE.

The ASRS was established in 1975 under a Memorandum of Agreement (MOA) between the Federal Aviation Administration (FAA) and National Aeronautics and Space Administration (NASA). The FAA provides most of the program funding, while NASA administers the program and sets its policies. This cooperative safety reporting program invites pilots, controllers, and other users of the NAS to report to NASA actual or potential deficiencies involving the safety of aviation operations. At the time of this search, the ASRS database contained 48,193 full-form reports received since January 1, 1986.

ASRS data are used to support planning and improvements to the NAS, and strengthen aviation human factors safety research. All submissions to ASRS are completely voluntary and are held in strict confidence. Furthermore, the FAA determined that ASRS would be more effective if receipt, processing, and analysis were performed by NASA. This would ensure the anonymity of all reporters, as well as those involved in the incident. Consequently, this anonymity has increased the flow of information necessary for the effective evaluation of the safety and efficiency of the NAS.

The FAA offers ASRS reporters further guarantees to report safety incidents. It is committed not to use ASRS information in enforcement actions. It has also chosen to waive fines and penalties for unintentional violations of Federal Aviation Regulations (FARs) which are reported to ASRS. The FAA's initiation of ASRS and its agreement to waive penalties prove the importance it puts on gathering information about potential aviation safety deficiencies.

Incident reports are read and analyzed by ASRS aviation safety analysts. Each report is read by at least two analysts. Their first task is to look for any aviation hazards discussed in the reports. When a hazard is identified, an alerting message is sent to the appropriate FAA office. The analyst's next task is

to classify reports and determine the causes underlying each reported incident. Once analysis is completed the ASRS reports are ready to be de-identified and entered into the database. The de-identification process involves generalizing or eliminating information that could be used to infer an identity of the reporter.

## 2. BACKGROUND.

Many aviation accidents that are investigated by the National Transportation Safety Board (NTSB) are caused by breakdowns in information transfer--the communication among crew members and from a larger degree, between aircraft and ground-based facilities. Analysis of these accident reports has resulted in many design changes, from aircraft display issues to changes in communication procedures.

Nonetheless, it is not always the case that the cause of an error is known, thereby robbing the research community of an explanation for such accidents. In an attempt to gain further information with regards to deficiencies and discrepancies in the NAS, the ASRS was established to collect anonymous accounts of incidents that have safety implications that have not, necessarily, resulted in a catastrophic event. The review and analyses of the ASRS data has resulted in a further understanding of the pilot/crew and controller environments and the problems associated with both.

A frequently reported problem in the ASRS database is communication errors; errors resulting from communications between pilots and controllers and those among crew members themselves (Wiener, 1988; Lee and Lozito, 1989). The advent of digital communications (data link) into the NAS, in part, may alleviate communication errors by: (1) providing more efficient data routing and increase rates of information transfer, (2) eliminating crowded frequencies and congestion over the airwaves, and (3) reducing ambiguity in communication between pilots and controllers (Kerns, 1990). However, in spite of the many advantages, data link has the potential to increase the crew's task workload which, in turn, increases the potential for error and/or reduce situational awareness.

Maintaining situational awareness during piloting operations is essential for safe flight. Situational awareness is defined by one researcher as the following:

"Situational awareness is the pilot's internal model of the world around him at any point in time" (Endsley, 1988).

A component of situational awareness, the "party line," is used by pilots to help construct this internal model. The party line is a source of information that is provided through an open, active voice radio frequency. Pilots use the party line, for

example, to acquire information about other nearby aircraft, weather information, etc. The discrete addressing nature of data link eliminates the availability of party line information which reduces a pilot's overall situational awareness.

The goal of researchers then is to determine what party line information is useful to the flight crews and in what ways can the information be conveyed in a data link environment. Previous surveys (Brown, 1991; Midkiff, et al. 1993) of the airline pilot industry have determined that the importance of party line information is greatest near the terminal environment and that caution should be exercised when implementing data link in this environment. It is anticipated that this ASRS analysis will reveal similar findings.

### 3. OBJECTIVE.

The ASRS database was constructed to allow flight crews to report incidents or conditions that compromise safety of flight. The database is used extensively by researchers, for example, to address crew design concepts and in turn, formulate design recommendations.

The arrival of data link communications in the NAS is imminent. Many issues regarding the design of a pilot and controller digital link have been published (Boucek, SAE, 1991; ATA, 1989). One of these issues is the proposed loss of crew/controller situational awareness. In the current voice radio communications environment, flight crews claim to derive useful information from listening to the communications between controllers and other aircraft. Information regarding current weather conditions, such as ride reports generated by other aircraft, can be useful to flight crews. This potential loss in situational awareness may have an adverse effect on the flight crews.

This report analyzes the results of a search of the ASRS database. The focus was on the crew's use of the party line, the actions and frequency of errors attributed to its use. The results, both positive and negative, will be judged in the context of a data link environment.

### 4. PROCEDURE.

An inquiry of the ASRS database requires a list of keywords which convey the topic search of interest. To help in identifying keywords, a list of candidate keywords were identified by the Crew System Ergonomics Information Analysis Center (CSERIAC) FAA staff from previous knowledge of situational awareness and the party line. These keywords were then tested by conducting searches of a variety of databases, such as the National Technical Information Service (NTIS), in order to obtain scientific research reports on the topic areas. Relevant reports were further screened for additional keywords. The original list and keywords obtained from the scientific research were then

combined and reduced to a more specific list. Table 1, below, contains the keyword list as it was sent to ASRS.

TABLE 1. SITUATIONAL AWARENESS/PARTY LINE KEYWORD LIST

Situational Awareness and Workload  
Party Line  
Situational Awareness and TCAS  
Situational Awareness and Air Traffic Control (ATC)

This list was faxed to ASRS along with a cover letter describing that situational awareness/party line was the area of concern for our search. A followup phone call was placed to ASRS to discuss any problems or concerns with the keyword list for the search. After receiving our keyword list, ASRS needed 4 weeks to perform our search and send us the results in electronic form.

Upon receipt of the ASRS search results, each report (300 total) was read by two CSERIAC staff members. Selection of valid reports were based on two criteria: (1) the report contained actual voice transmissions heard over the party line, or (2) if not an actual transmission, then at least a reference to its use. Based on the first criteria, a total of 85 individual PLI elements were extracted from 78 reports; 7 reports contained 2 PLI elements. These will be discussed in section 5.2 (Party Line Analysis). Based on the second criteria, a total of seven reports were collected. These will be discussed separately in section 5.3 (Further Discussion).

A roundtable discussion with group members resulted in the development of a PLI classification scheme. Based on the classification scheme, additional information was gathered on each PLI element. A table, complete with information regarding each PLI element, was created and is provided in appendix A (PLI Element Classification Table). For the interested reader, the entire list of useful reports is provided in appendix B (Full Form Reports).

## 5. RESULTS AND DISCUSSION.

The reports selected for analysis contained a variety of different uses of party line information. A select few, for example, were more prevalent than others. Although this is so, the reader is reminded that the reports are voluntary and that they do not reflect the total population of party line information used by flight crews. Research, such as that conducted by Midkiff and Hansman (1993), report more exhaustive surveys. In addition, the sampling characteristics of the ASRS database preclude any inferential analysis of the data; only descriptive statistics, expressed as percentages will be provided.

Further, flight crew actions based on the party line may or may not have contributed to the resultant safety incidents that were

reported; other factors, out of the scope of this report were involved.

Nevertheless, the party line was used primarily to maintain traffic awareness and to help avoid more serious conflicts; this global mindset of the crews was so appropriately put in the words of one pilot as the following:

"I hate to think what would have happened if I had not been listening to the radio and noticed the other plane coming in" (ASRS, 188555).

This section is divided into three sections. The first section provides introductory information, including definitions of the data extracted from the report narratives. The second section provides the analysis of the PLI elements and the third section contains a general discussion on party line issues not contained in the analysis.

#### 5.1 CLASSIFICATION/DEFINITION OF DATA.

When a safety incident is sent to the ASRS, analysts file the report according to a standard format. This format contains various kinds of information about each incident, from facility state to aircraft type, etc.; this information is straightforward and easy to compile. However, for the purposes of the CSERIAC analysis, most of the information was derived from the narrative section of the reports; the narratives varied in length and descriptiveness. Discussion sessions were used to identify the PLI elements, which were less straightforward and required more interpretation.

The analysis of the reports resulted in the defining of specific terminology. These terms are used throughout the report to describe the results and are operationally defined below. Bolded text within the definitions refer to additional terms that are defined in the list.

## Party Line Informational Element (PLI)

A type of information that was conveyed over the party line.

### Instructional

Information provided to the **receiver** (typically a pilot) which required an immediate control action or execution of a clearance.

### Advisory

Information which did not require an immediate control action. For example: a weather report, position/traffic report, etc.

### Listener

The flight crew or controller who overhears the **party line information**. For example, flight crew A (the **listener**) hears flight crew B receive an altitude clearance.

### Receiver

The flight crew or controller who received an **instructional** or **advisory** message. In the example above, flight crew B would be the **receiver**.

### Transmitter Source

The person (ATC or pilot) who transmitted the **party line information**.

### Listener Action

The action of the **listener** immediately subsequent to and based on the information heard over the party line.

### Resulting Incident

The safety incident or event which was reported. The actual safety incident may or may not have been a direct result of the **party line information**.

Table 2 provides a description of the data that was obtained from the ASRS reports. The items listed are extensions of the terminology used above whereas others, such as type of aircraft, weather conditions, etc., are self-explanatory. In any case, table 2 contains a complete summary of the classification of data (ordered by report section) that was gathered for each of the 85 PLI elements discovered in the analysis.

TABLE 2. CLASSIFICATION OF DATA

Description	Definition
Transmitter Frequency: Section 5.2.1	The frequency or controlling agency in which the party line information was conveyed. Usable frequencies: AIR (Airport, non-tower, non-controlled), APP (Approach), CTAF (Common Traffic Advisory Frequency), CTR (Center), DEP (Departure), GND (Ground) and TWR (Tower).
Type of Aircraft: Section 5.2.1	This was derived from the Aircraft Type section of the ASRS reports. Where appropriate, the report narrative was also used to determine the aircraft involved in the party line transmission.
Party Line Information Element (PLI): Section 5.2.2	A type of information that was conveyed over the party line.
Transmitter Source: Section 5.2.2	The person (ATC or pilot) who transmitted the party line information.
L-R/T Environment: Section 5.2.2	This category identifies the configuration (Air vs. Ground) of the aircraft involved during the party line transmission. For example: A-A represents that the listener (L, before hyphen) was in the air when hearing the party line transmission. The receiver (R), or transmitter (T) of the party line was also in the air.
Listener Action: Section 5.2.3	The action of the listener immediately subsequent to and based on the information heard over the party line.
Resulting Incident: Section 5.2.4	The safety incident or event which was reported. The actual safety incident may or may not have been a direct result of the party line information.
Transmission Correct/Incorrect: Section 5.2.5	An indication of whether the transmitted PLI element was correct or incorrect.
Listener Action Correct/Incorrect: Section 5.2.5	The correctness or incorrectness of the listener action based on the transmitted PLI element.
Weather Conditions: Section 5.2.5	This was derived from the Flight Conditions section of the ASRS reports. Allowable conditions are: VMC (Visual), IMC (Instrument) and MXD (Mixed).

## 5.2 PARTY LINE ANALYSIS.

A total of 85 PLI elements (reports) were identified as useful to this task. These were obtained from 300 individual reports which equates to an overall hit rate of 28 percent. Due to the large number of reports, it is impossible to discuss each incident individually. Consequently, the focus of the following sections will be to describe summary information about the data. Graphs, tables, etc., will be used to help convey the information. In some instances, example narratives will be used to provide emphasis.

### 5.2.1 Controlling Agency/Type of Aircraft.

A key element in the analysis is the identification of the controlling agency. The amount of party line information increases with proximity to the ground and airport surface. The information is reportedly used to preprogram flight management systems (FMS) and to help maintain traffic awareness. Weather information, such as ride reports, is also used to the flight crews advantage.

Figure 1 shows the distribution of controlling agencies involved in the reports. Sixty percent of the incidents reported party line transmissions over the tower frequency. The tower controller's (or local controller's) responsibility is for operations on the active runway for both departing and arriving traffic.

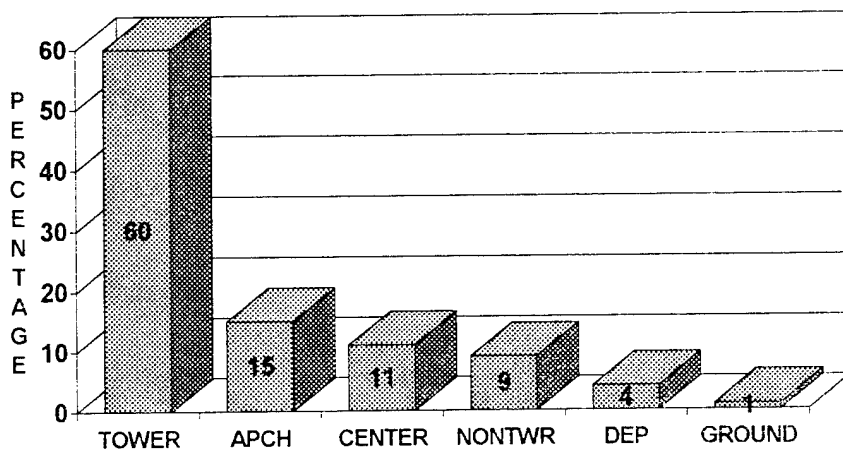


FIGURE 1. CONTROLLING AGENCY

Responsibilities for departing aircraft include providing departure procedures, traffic information, takeoff clearances and taxi instructions such as position and hold, hold short, etc. Arrival responsibilities include, among others, landing clearances and runway exiting procedures. Advisory type information, such as runway braking reports, surface wind

conditions and parked vehicles (e.g., snow removal trucks) are also the responsibility of the tower controller (Air Traffic Control Handbook, 1982).

Only 11 percent of the reports involved the center frequency. The majority of these reports involved altitude instructions that were incorrectly taken because of missed call signs. The others involved either position reports, holding instructions, or traffic information. When considering all but the center frequency, the percentage of PLI elements conveyed at or near the airport increases to 89 percent. This supports the research literature of Brown, 1991 and Midkiff, et al., 1993, in that the party line is used more extensively near the airport.

Figure 2 portrays, in order of occurrence, the various types of aircraft involved in the incidents. Note: The aircraft of both the listener and the receiver of the party line information were counted in the data. The majority of aircraft involved in the incidents were Small Aircraft (SMA) (30 percent) flying under Visual Flight Rule (VFR) conditions.

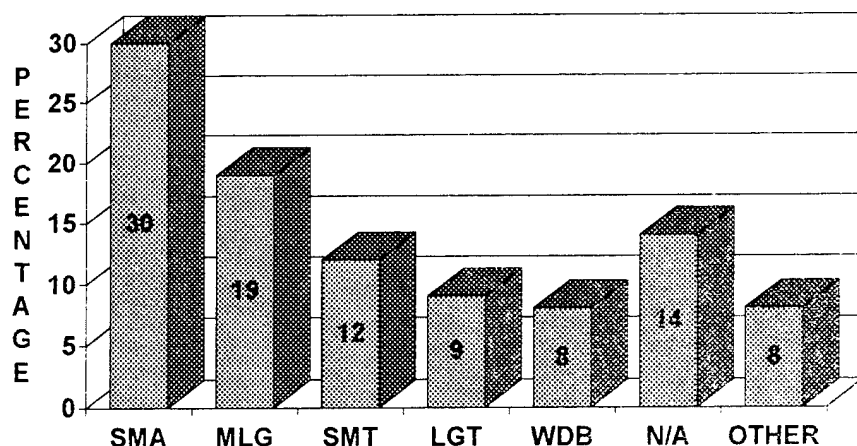


FIGURE 2. TYPE OF AIRCRAFT

The rest, in order of their occurrence: Medium Large Transport (MLG) (19 percent), Small Transport (SMT) (12 percent), Large Transport (LGT) (9 percent), Wide Body (WDB) (8 percent) and Other (8 percent). Fourteen percent of the aircraft were unable to be determined from the report.

Systems such as the Traffic Alert and Collision Avoidance System (TCAS) can help pilots determine the usefulness of party line transmissions. Only 4 of the 85 reports contained references to the use of TCAS. When considering the large number of small aircraft, this is not hard to infer given that many small aircraft do not have TCAS. To examine the data even further, almost 60 percent of the reported incidents that involved incorrect flight crew actions involved small aircraft. This may

be due to single pilot operations versus multiperson crews, absence of available support systems (TCAS), and so on.

### 5.2.2 Type of Information.

Each of the 85 PLI elements were categorized as instructional (61 percent) or advisory (39 percent) type information. Examples of instructional elements are altitude, headings, takeoff, and taxi clearances/instructions. Examples of advisory messages are weather information, position reports, and traffic reports.

Figure 3 depicts the distribution of the advisory PLI elements found in the reports. The breakdown is as follows: Runway/Landing Intentions (27 percent), Position Report (25 percent), Weather Information/Conditions (18 percent), Traffic Reports (12 percent), Go-around Intentions (9 percent) and Other (9 percent). Traffic reports were considered separate and distinct from position reports as they were information conveyed by air traffic control; position reports were conveyed by flight crews.

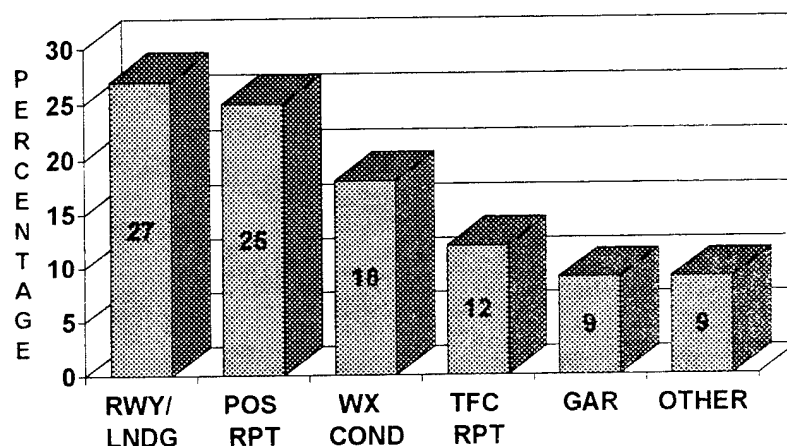


FIGURE 3. ADVISORY PLI ELEMENTS

Figure 4 depicts the distribution of the instructional PLI elements. The breakdown is as follows: Takeoff/Departure Clearances (27 percent), Altitude Clearances (17 percent), Taxi/Runway Clearances (17 percent), Approach/Landing Clearances (14 percent), Heading/Vector Clearances (11 percent) and Other (14 percent). The other category contained less prevalent elements such as information regarding missed approaches, touch and go's, holdings, etc. Three of the top four categories involved operations at or near the airport surface; this again, portrays the prevalence of party line information in the terminal environment.

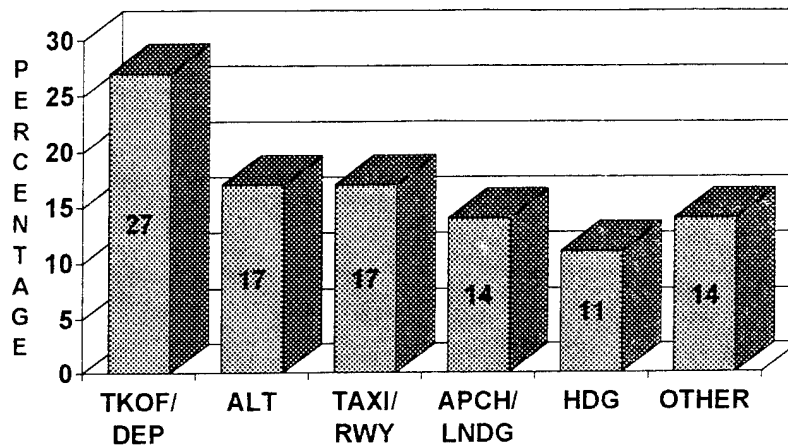


FIGURE 4. INSTRUCTIONAL PLI ELEMENTS

Table 3 provides percentage data of the breakdown of the two types of PLI elements, either advisory or instructional, and the person/source who transmitted the information. The most revealing characteristic is that flight crews provided mainly advisory information (96 percent), whereas ATC provided mainly instructional information (86 percent).

TABLE 3. SOURCE BY TYPE

	Advisory	Instructional		Advisory	Instructional
Air	96%	4%	ATC	14%	86%

Table 4 provides an indication of the configuration of the parties involved. Specifically, the first column indicates the environment of the listener (first letter) and the receiver (second letter) at the time of the party line transmission. For example, A-G, represents that the party line listener was airborne, whereas the receiver was on the ground. This would represent, e.g., an arrival aircraft on final overhearing another aircraft receive a takeoff clearance on the same runway. The second and third columns are as before; the data is separated into both informational types. The last column depicts the overall percentage distribution of the four available configurations.

TABLE 4. AIRCRAFT CONFIGURATION

L-R	Advisory	Instruction	Overall
A-A	67%	48%	55%
A-G	9%	10%	9%
G-G	12%	32%	25%
G-A	12%	10%	11%

Overall, 80 percent of the party line transmissions involved aircraft in the same environment. Either both were in the air, or on the ground. Most controlling agencies control aircraft in one or the other environment. On the other hand, tower responsibilities include both environments. This is why some reports revealed mixed configurations. The importance of party line information near the airport is further exemplified when considering just tower operations. Seventy percent of all tower transmissions involved at least one ground component (A-G, G-G, and G-A).

To summarize, the data does not represent the total population of PLI elements; a formal questionnaire or survey of the pilot industry may provide more information. Nonetheless, it would be safe to say that the PLI elements found in these reports would all be considered useful to the flight crews.

#### 5.2.3 Listener Action.

This section summarizes the different actions executed by the listener of the party line information. The actions were based directly on the PLI element and were further designated as either incorrect or correct. Section 5.2.5 (Error Analysis) expands on this section by providing illustrative examples of flight/crew narratives.

Figure 5 provides a distribution of the listener actions that were based on the party line. The following actions were identified: Evasive Action (EVA) (33 percent), Continued Clearance (CC) (28 percent), Query Controller (QC) (12 percent), Executed Unauthorized Clearance (EUC) (11 percent), Query Aircraft (QA) (6 percent), Weather Awareness/Avoidance (WXA) (6 percent) and Other (OTHR) (4 percent). Actions that were not as

prevalent (e.g., request clearance, programming of the FMS) were combined into the Other category.

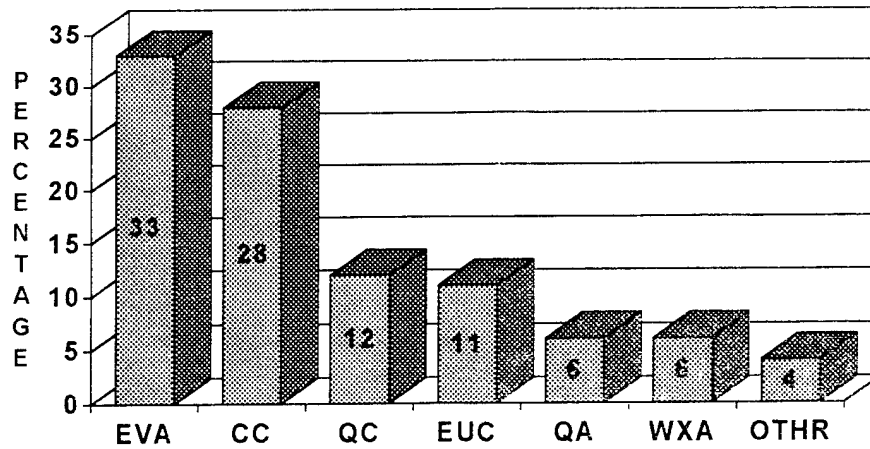


FIGURE 5. LISTENER ACTIONS

Table 5 shows the percentage of correct and incorrect actions for each listener action. The highlighted cell, indicates that the majority of incorrect actions by the flight crews were attributed to execution of unauthorized clearances. These were counted as incorrect actions because the flight crews accepted clearances that were intended for someone else. Similar call signs and radio clutter added to the confusion.

TABLE 5. LISTENER ACTIONS - CORRECT/INCORRECT

	EVA	CC	QC	EUC	QA	WXA	OTHR	Overall
Correct	97%	64%	100%	0%	100%	100%	50%	74%
Incorrect	3%	36%	0%	100%	0%	0%	50%	26%

As is evident from the data, the majority of flight crew actions were correct (74 percent). In fact, the party line was used in some instances to correct potential errors that may have gone undetected in a data link environment. Flight crews would either query the controller or other aircraft to amend the situation.

Also, the majority of correct flight crew actions were to execute evasive maneuvers. Some examples of evasive maneuvers were: (1) executing a go-around or missed approach because of aircraft on runway, (2) runway traffic avoidance to avoid conflict with landing aircraft and/or taxiing aircraft, and (3) aborted takeoff. Flight crews were able to avoid conflicts by performing the evasive maneuvers; if it was not for the party line, they may never have been aware of the potential conflicts.

#### 5.2.4 Resulting Incident.

The previously mentioned data represents a portion of the narrative reports. To completely summarize each report, the ASRS analysts provided a brief description of the safety incident, such as, airborne conflict, near midair collision (NMAC), etc. In all cases, the description denotes a ``negative'' connotation - which it should. However, ``positive'' contributions owing to the party line were evident throughout the reports.

Each of the reports were further screened by CSERIAC to assess the positive and negative contributions owing to the party line in the context of the safety incidents that were reported. Specifically, flight crews which performed an evasive action based on the party line were denoted as ``positive'' resulting incidents. This was so because they avoided a potential conflict, even if the incident as noted by ASRS was a NMAC or ground conflict. Altitude deviations, track deviations, etc., resulting from flight crews taking another aircraft's clearance were denoted by CSERIAC as ``negative'' resulting incidents.

Table 6 depicts the percentage distribution of the resulting incidents. The first column identifies the incident that was reported and the second column denotes whether the incident was positive (P) or negative (N).

TABLE 6. RESULTING INCIDENT

Resulting Incidents	P/N	%
Conflict Avoidance/Air (CA/A)	P	22
Conflict Avoidance/Ground (CA/G)	P	17
Ground Conflict (GC)	N	12
Air Conflict (AC)	N	9
Near Mid-Air Collision (NMAC)	N	8
Runway Transgression (RTG)	N	7
Undetermined (N/A)	-	7
Weather Avoidance/Awareness (WXA)	P	5
Altitude Deviation (AD)	N	5
Heading Deviation (HD)	N	3
Other	N	2
Unauthorized Takeoff (UT)	N	2
Track Deviation	N	1

To conclude, while it is true that incorrect listener actions (EUC) always led to ``negative'' resulting incidents, it is possible for correct listener actions (EVA, QC, QA, etc.) to result in either positive or negative resulting incidents. The latter is true, because of other factors such as controller error, system error, etc., that were involved in the incidents.

### 5.2.5 Error Analysis.

The discussion that follows expands on the previous sections by showing how all the information is related to one another. This was accomplished through an error analysis; taking each component of the party line, from the transmission of the information to the actions performed by the flight crews and determining where the problems lie. The results of this analysis are depicted in the error analysis tree shown in figure 6.

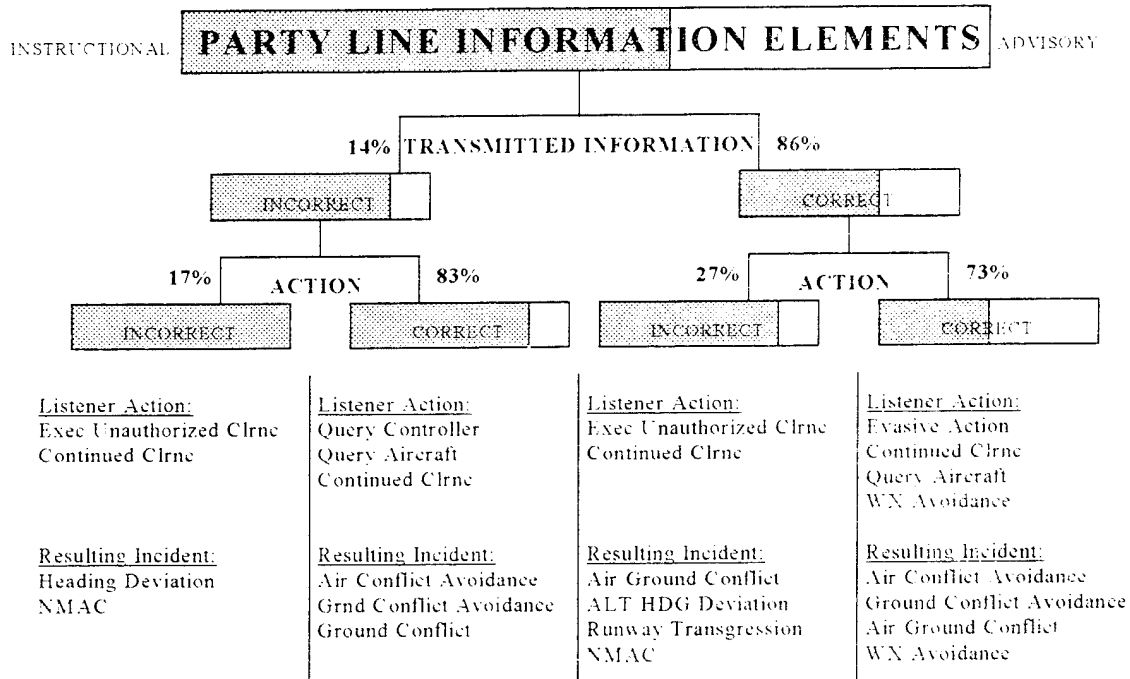


FIGURE 6. ERROR ANALYSIS TREE

There are two different kinds of errors that are directly attributed to the information conveyed over the party line. They are as follows: (1) errors attributed to incorrect transmission (first level branch); and (2) errors resulting from incorrect actions by the flight crews (second level branch).

The numbers along the branches (outside the boxed areas) are percentages of the various conditions. For example, 14 percent of the PLI elements were transmitted incorrectly. Continuing down the same branch, 17 percent (of the incorrect transmissions) resulted in an incorrect listener action and 83 percent resulted in a correct listener action. The shaded area within the boxes represents the percentage of instructional PLI elements and the nonshaded area represents the advisory PLI elements.

What unfolds on the second level branch then, are four separate error categories, from left to right: (1) Incorrect Transmission, Incorrect Action (II); (2) Incorrect Transmission, Correct Action (IC); (3) Correct Transmission, Incorrect Action (CI); and (4) Correct Transmission, Correct Action (CC). Table 7 provides the number of occurrences and overall percentages for each condition. The percentages are based on the entire list of 85 individual PLI elements used in the analysis.

TABLE 7. ERROR CATEGORY PERCENTAGES

Statistic	Error Category				Total
	II	IC	CI	CC	
n	2	10	20	53	85
%	2	12	24	62	100

The third and fourth levels of the tree are the listener action and the resulting incident, respectively. The lists provide a summary of those actions and incidents which occurred most often for each of the four error categories; the first listed item occurred the most often, the second listed item next, and so on down the list.

To illustrate further, each of the error categories described in table 7, is discussed below along with example narratives to provide emphasis.

#### Incorrect Transmission, Incorrect Action

Two situations resulted in an incorrect action based on an incorrect transmission. Both incidents involved the controller issuing an instruction. The incident that follows was a situation where two successive departing aircraft, under tower control, passed within 1 1/2 miles of each other. The tower controller was decertified for not providing legal separation of the two departing aircraft. However, one aircraft (the listener of the party line) did not help matters any:

"IFR weather, runways 7 and 15L/R in use. SMA X was on ILS approach/missed approach runway 7. Missed approach instructions were nonstandard and coordinated by radar controller. Runway heading until 700', then turn right heading 200 degrees, climb and maintain 2000'. SMA Y called for departure IFR to VFR on top runway 15L. Release was obtained from radar. SMA Y was given traffic (SMA X) 2 mile final runway 7 and cleared for takeoff runway 15L runway heading climb to VFR on top 2000'. SMA X executed missed approach 1/2 mile final, was instructed to fly runway heading until departure end then turn to 200 degrees. SMA Y was now 2 miles south at 1300' talking to departure. SMA X began turn

to 200 degrees approximately 1/2 mile beyond departure end...Radar controller gave SMA X right turn to 100 degrees while aircraft was still on local frequency. SMA Y heard the heading issued the SMA X and turned left to 100 degrees..." (ASRS, 109535).

In the preceding example, the SMA Y aircraft incorrectly took a heading clearance intended for the SMA X aircraft, and compounded matters even further by turning the wrong direction. The heading clearance was transmitted incorrectly for reasons cited before; i.e., controller separation error.

#### Incorrect Transmission, Correct Action

This category conveys the importance of the party line, in that flight crews would either question the controller or another aircraft in response to the information heard over the party line. In terms of the data, 83 percent of incorrectly transmitted information resulted in the correct action of the flight crew. The following example illustrates the most common action taken by the flight crews--querying the controller.

"I was captain on ACR X, Boston to Miami. We were holding at the published pattern at CCE on the Collier 2 arrival into Miami at FL260...During this time the controller was giving an expect further clearance (EFC) to all aircraft in the pattern of XX05Z. I thought this was rather strange as I had always observed each aircraft receiving an individual time. As we were inbound on holding (10 mile legs over the VOR) the controller issued a descent clearance to an ACR Y flight to FL250. I thought this strange as we should have been next to FL250. I asked the controller if he was handling any other holding patterns. He said no...After a brief pause, another voice came over the radio telling us to turn immediately to a heading of 180 (south and away from the holding pattern)...then were given a turn to 360, then a turn to join the inbound leg of the pattern of the VOR. In my opinion, the controller descended the ACR Y through our altitude block." (ASRS, 191230).

The pilot later commented:

"Even though you can't see aircraft, it's good to listen up on the radio and make a mental picture of the aircraft around you, i.e., holding on approach, etc." (ASRS, 191230).

This incident eventually led to two aircraft with less than standard separation apart. The resulting incident, conflict avoidance/air, was positive even though it was another alert controller who initiated the vectors away from the holding pattern.

### Correct Transmission, Incorrect Action

This category was a result of flight crews executing an incorrect action based on a correct transmission. Overall, 24 percent of the reports met this criteria. The action most commonly taken was execution of unauthorized clearances, this occurred almost half (45 percent) of the time. An artifact of the party line, because it is an open transmission, is that flight crews will sometimes inadvertently take clearances intended for other aircraft. The consensus in the reports, was that similar call signs added to the confusion.

A third (33 percent) of the actions were a result of the flight crews continuing their present clearance. Flight crews chose to continue their present clearance even after hearing the party line transmission. Flight crews very seldom make decisions based on party line information alone, yet in these instances, their action of omission was wrong. As in the following example, these types of problems were compounded further by having a false mental picture of the situation:

"After landing on runway 16R in Seattle we were cleared to cross runway 16L and told to contact ground when crossed. While we are approaching and very close to runway 16R on the 'high speed' ACR Y was cleared for takeoff. We both thought he was cleared for takeoff on runway on 16R. He was taking off on runway 16L. By that time we were on 16L. We cleared the runway ASAP, and ACR Y aborted his takeoff" (ASRS, 115928).

Similarly, inexperienced pilots who are unfamiliar with airport surroundings may act too abruptly when confronted with information over the party line. To conclude this error category, the following example describes an incident where an inexperienced pilot reacts too quickly, and in so doing, transgressed an active runway:

"Contacted LGB W for landing and informed on initial contact that pilot was unfamiliar. Was instructed to enter right downwind for 25R. Landed and during rollout was instructed, 'Left Next Taxiway,' but at this point was unable to positively ident the next opening as a taxiway...Immediately after receiving this instruction, another aircraft (which was already holding position on 25R) was cleared for takeoff 25R. Hearing this caused me to panic. I was afraid of crossing runway 30 which I had been given landing instructions to hold short of, but with the plane behind me cleared for takeoff I didn't have enough time to verify my position with the tower as so took the next left to clear the runway, which turned out to be the approach end of 16R...This situation occurred partly due to my lack of experience as a pilot, and

limited experience with unfamiliar airports." (ASRS, 103105).

#### Correct Transmission, Correct Action

The majority of incidents (62 percent) fell into this category; i.e., both the transmitted information and listener action were correct. This supports the use of the party line in that flight crews used the information to maintain traffic awareness in order to avoid potential conflicts.

The most common action reported was EVA (53 percent); the second most occurring action was continued clearance (25 percent). Unlike the previous category, continued clearance actions were considered correct actions; pilots had no reason to depart from their present clearance given the information that was presented over the party line. The following narrative describes such a situation:

"Flight was cleared for a visual approach to runway 14 to follow an ACR Y LGT Y. Approach advised us to slow to 210 kts until reaching PORGY intersection and to contact tower at PORGY. Approach control asked commuter SMT if it had our LGT in sight. SMT replied it had us in sight. Approach control then issued a clearance to follow our LGT to runway 14 and cleared it for a visual approach and to contact tower frequency. Approximately 1100' MSL (3 miles from end of runway) we noticed SMT on our L and slightly above us (approximately 200' separation both lateral and vertical) turning from a left base to final. At the point, evasive action was taken by rapidly descending to 800' MSL and accelerating with execution of missed approach. After clearing traffic we climbed up to 2000' MSL and returned to field with no further action." (ASRS, 153054).

The crew in the above incident was aware of traffic in the area and eventually had to perform an EVA. However, the EVA was executed at a later time when the potential conflicting situation unfolded. Tower was blamed in this incident for not advising the LGT of traffic and/or a traffic conflict. As is evident from this report, other factors not directly attributed to the party line transmission were involved in the incident. The resulting incident, airborne conflict, was negative even though the listener action, continued clearance, was correct.

The next example illustrates the flight crew performing an EVA (aborted takeoff) based directly on the information conveyed over the party line:

"Approaching runway 25R, tower cleared us (ACR AB XYZ) for takeoff. We began our takeoff roll when we heard the tower advise ACR CB XYZ to hold short of 25R after

landing. He was landing on 25L. The FO was making the takeoff and because of the common flight number he hesitated very briefly advancing power levers until I mentioned the transmission was not for us. As we were accelerating, I noticed CB XYZ turning off 25L at a fairly rapid speed and thought he might not be stopping short of our runway. I watched him and at about 115 kts it was clear to me CB XYZ wasn't stopping, so I aborted the takeoff. At about the same moment CB XYZ made an abrupt stop with his nose slightly extending onto runway 25R. We stopped short of his position and without incident" (ASRS, 202475).

The aforementioned categories indicated the types of errors that were found in the incident reports. Other factors independent of the party line may contribute to these errors. For instance, a pilot's ability to "see and avoid" can be affected during adverse weather wherein the visual component cannot be used to confirm the information conveyed over the party line.

Table 8 provides a capsule look at the various error categories and the percentage distribution of weather conditions that were reported. The data reflects that the majority of incidents reported were under Visual Meteorological Conditions (VMC). Furthermore, the data suggests that incorrect actions were not necessarily the result of Instrument Meteorological Conditions (IMC). In fact, the reverse is true; even when conditions were VMC, pilots still made errors.

TABLE 8. WEATHER CONDITIONS

Weather	Error Category			
	II	IC	CI	CC
IMC	50%	40%	10%	26%
VMC	50%	60%	90%	74%

In summary, the analysis has shown that flight crew errors occur with the use of the party line; those attributed to incorrect transmission of information (14 percent) and those resulting from incorrect actions (26 percent). The majority of errors (46 percent) were a result of flight crews accepting clearances intended for other aircraft; these were compounded further by the presence of similar call signs. Thirty-three percent of all pilot actions involved evasive maneuvers. Without the party line, these incidents may have been more serious. Furthermore, it was shown that adverse weather conditions did not significantly contribute to the errors reported.

### 5.3 FURTHER DISCUSSION.

Section 5.2 provided an analysis of incident reports containing explicit party line transmissions. A few reports did not contain party line information, however, they did contain information which supports its use. The majority of these reports involved incidents where two aircraft, operating in close proximity, were on different frequencies. To best describe the problem, short excerpts from a few of these reports are provided:

"...Had we been on the same frequency (UHF vs. VHF), we would have known about the problem..." (ASRS, 98555).

"...I feel this incident occurred because the tower did not advise MLG Y of my position and also because 2 different frequency bands were being used. Had Y been on VHF, they would have heard my transmissions. I feel that in the interest of safety, all aircraft operating in close proximity under ATC control be on the same radio band and frequency" (ASRS, 100007).

"...After speaking with TRACON after landing, it seems to me that the problem was with the handoff from tower to approach/departure. When we first sighted the other aircraft, he was still on tower frequency, so neither of us had the advantage of hearing the radio transmissions to each other." (ASRS, 128730).

The absence of the party line in these situations was definitely a factor in the safety incidents that occurred; all three resulted in near midair collisions.

It was mentioned that many flight crew errors were a result of similar call signs. The congestion over the airwaves sometimes produces much confusion, and in some cases, abbreviated transmissions. It can be very easy to inadvertently take other aircraft clearances.

To conclude this section, there is another form of clutter that affects the transmission of party line information; clutter influenced by different languages. One pilot, who had no specific safety incident to describe, provided the following:

"You mentioned you wanted international comments. Both in parts of Canada and in France the controllers regularly speak French to French speaking carriers. They do this in all areas of flight (taxi, takeoff, approach, etc.). In bad weather and/or overseas when you are unsure of routines, VORs, etc., it is very disturbing. Much is gained by hearing clearances given to other aircraft, not only in knowing what to expect, but to be able at times to verify that you are preceding as you thought cleared." (ASRS, 142041).

## 6. CONCLUSIONS.

### 6.1 GENERAL.

This study revealed that the majority of PLI elements were transmitted near or on the airport surface, which supports previously cited literature. As traffic is funneled into or released from the terminal environment, conditions are more favorable for accidents and/or incidents that compromise flight safety. Therefore, pilots use the party line to help construct a mental picture of their immediate environment in hopes to avoid these situations. In some cases, false or misleading information can distort this mental picture. However, this report revealed an overwhelming tendency for flight crews to question false transmissions over the party line, whether transmitted by controllers or other aircraft; the so-called "buddy-buddy" system was at work.

It was also shown, based on the actions exhibited by the flight crews, that the ability to "see and avoid" was aided by transmissions over the party line; a large majority of flight crew actions were evasive maneuvers. They were used to avoid conflicts in both the air and on the ground.

Many additional factors, other than transmissions conveyed over the party line, caused the incidents that were reported. System breakdowns, similar call signs, pilot and controller trainees, etc., were all involved in the incidents. Regardless of whether information was transmitted correctly or whether crew actions were correct, the party line was not enough to compensate for some incidents that were reported; this was reflected in the large number of negative resulting incidents that were reported.

The ASRS standard format does not provide the number of crew members and this was not always evident in the report narratives. Nonetheless, a large number of reports involved small aircraft--probably single pilot operations. It was also shown that the majority of incorrect flight crew actions involved aircraft of this type; the availability of an additional crew member or the presence of an onboard TCAS system could have been used to aid the pilot in these situations.

To conclude, the party line has been, and continues to be an excellent source of useful information to the flight crews. It has been shown that errors attributed to its use can occur, as is evident with other communication systems. The question is, what kind of errors, if any, will occur without it?. The next section deals with this issue.

### 6.2 DATA LINK INTERPRETATIONS.

The usefulness of the party line has never been more addressed within the research community as it is today. The reason is primarily due to the advent of a digital data link system. An

aspect of a digital data link system is that aircraft will be uniquely addressed as opposed to a broadcast over a voice frequency, as is today. An artifact of this, is that transmissions heard over the party line will be eliminated. Potential positive and negative effects, attributed to the loss of the party line will be discussed below.

Early stages of domestic data link are likely to provide ATC services, such as altitude assignments, frequency changes, etc., within the en route environment. Based on the data obtained in this report, only 11 percent of the reported party line transmissions involved the CTR controlling agency. Given the low percentage of PLI elements in this environment, the loss of the party line may not be as much of a concern to flight crews compared to other environments. In this report, over half of the information conveyed by center was altitude clearances (55 percent). Given that early planned services are to provide altitude clearances, one might infer that this would have a negative effect; quite the contrary, the majority of those transmissions were incorrectly taken by other aircraft. In a data link environment, errors attributed to similar call signs would be eliminated. A negative aspect is that information regarding ride reports from other aircraft would also be eliminated. Ride reports are used by flight crews; e.g., to request a different altitude to avoid turbulence, icing, etc.

On the other hand, care should be taken when implementing data link in the terminal environment. Information regarding departing or landing aircraft, aircraft or vehicles on runway, braking action reports, missed approach or go-around aircraft, etc., were all important information used by the flight crews. Regardless of weather conditions, pilots still use the party line to gain information about other traffic. Without some other flightdeck system/device (such as a real-time display of ground operations) to supplement the loss of the party line, pilots would be blind to potential hazardous situations. Furthermore, in both environments, flight crews were able to correct controller errors by using the party line system. Without the party line, these errors may go unnoticed.

To conclude, data link is not the cure-all for the safety incidents that have been reported within. Some errors, such as similar call signs, will be eliminated; others, such as runway transgressions, may be increased. The dual frequency problems identified earlier represents a problem which will still exist even in a data link environment. The solutions are more complex and require a global assessment, beyond the capabilities of a data link system, of the NAS.

## 7. RECOMMENDATIONS FOR FUTURE WORK.

Further research should be conducted on the ASRS database. As data link is primarily geared toward the airline community, subsequent searches should be tailored towards those types; eliminating the small aircraft (SMA, SMT, etc.) may reveal a different class of PLI elements and actions exhibited by the large transport flight crews.

Data link aside, additional open-ended surveys may provide a better understanding of the benefits or deficiencies inherent with the party line.

Further research may also result in more reports containing references to the TCAS system. Knowing how the TCAS system helps (or hurts) the crew with information conveyed over the party line, designers can use this information to suggest additional improvements or modifications to the TCAS display that will aid the flight crews. Design improvements may result in additional systems separate and distinct from the TCAS system.

Followup surveys should be conducted after data link has been introduced into the NAS. Early planned implementation calls for a mixed environment; not all aircraft will be data link equipped. The followup surveys may reveal additional problems related to this environment.

Research using, e.g., the Reconfigurable Cockpit System (RCS) at the FAA Technical Center, can be conducted to identify the impact that data link will have on the party line. The most commonly used PLI elements (both reported here and in other surveys) can be evaluated within both a data link and voice environment. The testing environment will help isolate the problems and will provide more definitive design solutions.

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## 9. ACRONYMS AND ABBREVIATIONS.

AC	Airborne Conflict
AD	Altitude Deviation
APP	Approach
ASRS	Aviation Safety Reporting System
ASRS	Aviation System Reporting System
ATC	Air Traffic Control
CC	Continued Clearance
CC	Correct Transmission, Correct Action
CI	Correct Transmission, Incorrect Action
CSERIAC	Crew System Ergonomics Information Analysis Center
CTAF	Common Traffic Advisory Frequency
CTR	Center
DEP	Departure
DOD	Department of Defense
DOT	Department of Transportation
DTIC	Defense Technical Information Center
EFC	Expect Further Clearance
EUC	Executed Unauthorized Clearance
EVA	Evasive Action
FAA	Federal Aviation Administration
FARs	Federal Aviation Regulations
FMS	Flight Management System
FO	First Officer
GC	Ground Conflict
GND	Ground
HD	Heading Deviation
IC	Incorrect Transmission, Correct Action
IFR	Instrument Flight Rules
II	Incorrect Transmission, Incorrect Action
ILS	Instrument Landing System
IMC	Instrument Meteorological Conditions
KTS	Knots
LGT	Large Transport
MLG	Medium Large Transport
MOA	Memorandum of Agreement
MSL	Mean Sea Level
MZD	Mixed
NAS	National Airspace System
NASA	National Aeronautics and Space Administration
NMAC	Near MidAir Collision
NTIS	National Technical Information Service
NTSB	National Transportation Safety Board
PL	Party Line
PLI	Party Line Informational Element
QA	Query Aircraft
QC	Query Controller
RCS	Reconfigurable Cockpit System
RTG	Runway Transgression
SA	Situation Awareness
SAE	Society of Automotive Engineers
SMA	Small Aircraft
SMT	Small Transport

9. ACRONYMS AND ABBREVIATIONS (cont'd).

TCAS	Traffic Alert and Collision Avoidance System
TD	Track Deviation
TPM	Technical Program Manager
TRACON	Terminal Radar Control
TWR	Tower
UHF	Ultra High Frequency
UT	Unauthorized Takeoff
VFR	Visual Flight Rules
VHF	Very High Frequency
VMC	Visual Meteorological Conditions
VOR	VHF Omni-directional Range
WDB	Wide Body
WX	Weather
WXA	Weather Awareness/Avoidance

## APPENDIX A

### PLI Element Classification Table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION				TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT		(CORRECT OR (INCORRECT				LISTENER ACTION	RESULTING INCIDENT
			ENV L-R/T	TR SRC	RCV POS					TR	L INT	L ACT			

Advisory Party Line Elements: Correct Transmission, Correct Action															
121920	VMC	AIR	A-A	Air	Air	Air	SMA, Glider, ?	Runway Information /Intentions	A	C	C	C	C	CC	CA/A
193844	VMC	AIR	A-A	Air	Air	Air	LTT,SMA	Landing/Runway Intentions	A	C	C	C	C	CC	GC
160654	VMC	TWR	A-A	ATC	Air	Air	SMA(2)	Traffic Report	A	C	C	C	C	CC	NMAC
161078	VMC	CTR	A-A	Air	Air	Air	WDB,?	Position Report	A	C	C	C	C	CC	NONE
142920B	VMC	TWR	G-A	Air	Air	Air	SMT(2)	GAR	A	C	C	C	C	EVA	CA/A
151948	VMC	CTAF	A-A	Air	Air	Air	SMA(2)	Landing Intentions	A	C	C	C	C	EVA	CA/A
160210B	VMC	CTAF	A-G	Air	Grnd	Air	SMA(2)	Landing Intentions	A	C	C	C	C	EVA/GAR	CA/A
93273	VMC	APP	A-A	ATC	Air	Air	LTT,SMA	Parachute Jumpers	A	C	C	C	C	EVA	CA/A
151548	VMC	TWR	A-A	Air	Air	Air	SMA(2)	Position Information	A	C	C	C	C	EVA	CA/A
141056	VMC	AIR	A-A	Air	Air	Air	SMA(2)	Position Report	A	C	C	C	C	EVA	CA/A
153480	VMC	TWR	A-A	Air	Air	Air	SMA(2)	Position Report	A	C	C	C	C	EVA	CA/A
177457	VMC	TWR	A-A	Air	Air	Air	MLG(2)	RWY Intentions	A	C	C	C	C	EVA	CA/A
190783	IMC	DEP	A-A	ATC	Air	Air	MLG,?	Traffic Report	A	C	C	C	C	EVA	CA/A
174511	VMC	TWR	G-G	ATC	Grnd	Air	MLG,SMT	Freq. Contact /Traffic Advisory	A	C	C	C	C	EVA/AT	CA/G
102190B	IMC	TWR	G-A	Air	Air	Air	MLG,?(3)	GAR Intentions	A	C	C	C	C	EVA/RTA	CA/G
184839	VMC	TWR	A-A	ATC	Air	Air	SMA	Land Short	A	C	C	C	C	EVA/RTA	CA/G
142110	VMC	TWR	G-A	Air	Air	Air	MLG,SMT	Position Information	A	C	C	C	C	EVA/RTA	CA/G
157890	VMC	TWR	G-G	ATC	Grnd	Air	SMA,MDT	Transmission Interrupted	A	C	C	C	C	EVA	CA/G
102190A	IMC	TWR	A-G	Air	Grnd	Air	MLG,?(3)	WX Information	A	C	C	C	C	EVA/GAR	CA/G
185329B	VMC	TWR	A-A	Air	Air	Air	SMA(2)	Position Report	A	C	C	C	C	QA,EVA	CA/A
105191	VMC	AIR	A-A	Air	Air	Air	?(2)	Landing Information /Intentions	A	C	C	C	C	QA	NONE

Note: Acronym Key for Header and Table contents is at the end of the table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION				TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(CORRECT OR (INCORRECT				LISTENER ACTION	RESULTING INCIDENT
			ENV L-R/T	TR	SRC	RCV POS			TR	L ACT				

Advisory Party Line Elements: Correct Transmission, Correct Action (cont'd)														
188555	VMC	TWR	G-A	Air	Air	Air	SMA, LGT	Landing/Runway Intentions	A	C	C	C	QC, EVA/RTA	CA/G
133393	MXD	APP	A-A	Air	Air	Air	SMA(2)	WX Information / Avoidance	A	C	C	C	RC	CA/A
169841	IMC	APP	A-A	Air	Air	Air	SMA, ?	WX Conditions, Icing	A	C	C	C	WXA	WXA
149017	MXD	APP	A-A	Air	Air	Air	SMA	WX Information	A	C	C	C	WXA, QC	WXA
182661	IMC	TWR	A-A	Air	Air	Air	MLG, ?	WX Information	A	C	C	C	WXA	WXA
103715	VMC	TWR	G-G	ATC	Grnd	Grnd	WDB, SMT	WX Information / Winds	A	C	C	C	WXA, CC	OTHER

Advisory Party Line Elements: Correct Transmission, Incorrect Action														
129866	VMC	TWR	A-G	Air	Air	Grnd	MLG, ?	Flock of Birds	A	C	I	I	CC	AC
199428	IMC	TWR	A-A	Air	Air	Air	MLG, HVT	Approach/Landing Intentions	A	C	C	I	CC	GC, RTG
160210A	VMC	CTAF	G-A	Air	Air	Air	SMA(2)	Departure Intentions	A	C	C	I	CC	NMAC
181915	VMC	TWR	A-A	Air	Air	Air	SMA, ?	GAR	A	C	C	I	CC	NMAC

Advisory Party Line Elements: Incorrect Transmission, Correct Action														
166711	IMC	TWR	A-G	ATC	Grnd	Grnd	LGT	RWY Traffic Information	A	I	C	C	CC	GC
163786	VMC	CTAF	A-A	Air	Air	Air	SMA(2)	Position Report	A	I	C	C	S-Turns	NMAC

Advisory Party Line Elements: Incorrect Transmission, Incorrect Action ... None Reported														
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Note: Acronym Key for Header and Tab2e contents is at the end of the table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION				TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(CORRECT OR (INCORRECT			LISTENER ACTION	RESULTING INCIDENT
			ENV		RCV				TR	L INT	L ACT		
			L-R/T	SRC	POS								

Instructional Party Line Elements: Correct Transmission, Correct Action															
202138	VMC	DEP	A-A	ATC	Air	LGT(3)	Altitude Clearance	I	C	C	C	C	CC		AC
153054	VMC	APP	A-A	ATC	Air	LGT,SMT	Approach and Landing Clearance	I	C	C	C	C	CC		AC
145775	VMC	TWR	A-A	ATC	Air	WDB,BMB	Landing Clearance	I	C	C	C	C	CC		AC
149191	VMC	CTR	A-A	ATC	Air	WDB,MLG	Vector for Traffic	I	C	C	C	C	CC		AC
217638B	VMC	TWR	G-G	ATC	Grnd	LTT,MLG	Cancel Takeoff Clearance	I	C	C	C	C	CC		GC
164636	VMC	TWR	G-A	ATC	Air	SMT,?	GAR	I	C	C	C	C	CC		GC
160299B	VMC	TWR	G-G	ATC	Grnd	WDB,?	Hold Short	I	C	C	C	C	CC		GC
184688A	IMC	APP	A-A	ATC	Air	MLG(2)	Altitude Clearance	I	C	C	C	C	CC		NONE
142920A	VMC	TWR	G-A	ATC	Air	SMT(2)	Landing Clearance	I	C	C	C	C	CC		NONE
109866	VMC	TWR	A-A	ATC	Air	SMA(2)	Landing Clearance	I	C	C	C	C	EVA/GAR		CA/A
104390	IMC	TWR	A-A	ATC	Air	MLG,LTT	Missed Approach	I	C	C	C	C	EVA		CA/A
102921	VMC	TWR	G-G	ATC	Grnd	LTT,SMA	Takeoff/Departure Instructions	I	C	C	C	C	EVA		CA/A
142265	VMC	TWR	G-A	ATC	Air	MLG,SMA	Touch and Go	I	C	C	C	C	EVA		CA/A
202475	VMC	TWR	G-G	ATC	Grnd	LGT,MLG	Hold Short	I	C	C	C	C	EVA/AT		CA/G
115635	VMC	TWR	A-G	ATC	Grnd	MLG,SMA	Hold Short	I	C	C	C	C	EVA/MA		CA/G
85529	VMC	TWR	G-A	ATC	Air	LGT,SMT	Landing Clearance	I	C	C	C	C	EVA/RTA		CA/G
121909	MXD	TWR	A-G	ATC	Grnd	? (2)	Position and Hold	I	C	C	C	C	EVA/GAR		CA/G
159370	VMC	TWR	G-G	ATC	Grnd	MLG,MDT	RWY Crossing Clearance	I	C	C	C	C	EVA/AT,QC		CA/G
235833	IMC	TWR	A-G	ATC	Grnd	MLG,WDB	Takeoff Clearance	I	C	C	C	C	EVA/GAR		CA/G
112175	VMC	TWR	A-G	ATC	Grnd	SMT(2)	Takeoff/Departure Instructions	I	C	C	C	C	EVA/GAR		CA/G
185329A	VMC	TWR	A-A	ATC	Air	SMA(2)	Approach Clearance	I	C	C	C	C	QA		CA/A
100348	IMC	TWR	A-A	Air	Air	MLG(2)	Other	I	C	C	C	C	QA		NONE
181950	VMC	TWR	G-A	ATC	Air	LGT,LTT	Position and Hold	I	C	C	C	C	QC		CA/G

Note: Acronym Key for Header and Table contents is at the end of the table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION				TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(CORRECT OR (INCORRECT				LISTENER ACTION	RESULTING INCIDENT
			ENV L-R/T	TR	RCV	POS			TR	L		ACT		
										INT	ACT			

Instructional Party Line Elements: Correct Transmission, Correct Action (cont'd)														
171242	VMC	APP	A-A	ATC	Air		SMA,SMT	Departure Instructions	I	C	C	C	QC	NMAC
207989	MXD	APP	A-A	ATC	Air		LGT	Vectors for Traffic	I	C	C	C	QC	OTHER
76961	IMC	APP	A-A	ATC	Air		WDB,SMT	Vectors for WX	I	C	C	C	WXA	WXA

Instructional Party Line Elements: Correct Transmission, Incorrect Action														
119378	VMC	TWR	G-G	ATC	Grnd		SMA(3)	Hold Short	I	C	I	I	CC	GC,RTG
115928	VMC	TWR	G-G	ATC	Grnd		MLG(2)	Takeoff/Departure Instructions	I	C	I	I	CC	GC,RTG
102994	VMC	GND	G-A	ATC	Air		SMA,SMT	Touch and Go	I	C	I	I	CC	GC,RTG
210241	IMC	APP	A-A	ATC	Air		SMT,SMA	Approach Vectors	I	C	I	I	CC	NMAC
109950	VMC	APP	A-A	ATC	Air		SMA(2)	Vectors for Traffic	I	C	C	I	DROP JUMPERS	AC
159430	VMC	CTR	A-A	ATC	Air		MLG	Altitude Clearance	I	C	I	I	EUC	AD
196903	VMC	CTR	A-A	ATC	Air		LTT	Altitude Clearance	I	C	I	I	EUC	AD
110010	VMC	CTR	A-A	ATC	Air		MLG,?	Altitude Clearance	I	C	I	I	EUC	AD
154200	VMC	APP	A-A	ATC	Air		LGT	Altitude Clearance	I	C	I	I	EUC	AD,TD
190584	VMC	DEP	A-A	ATC	Air		WDB,?	Heading Clearance	I	C	I	I	EUC	HD
204663	VMC	TWR	G-G	ATC	Grnd		MLG	Takeoff/Departure Instructions	I	C	I	I	EUC	HD
147237	VMC	TWR	G-G	ATC	Grnd		MLG,?	Position and Hold	I	C	I	I	EUC	RTG
217637	VMC	TWR	G-G	ATC	Grnd		MLG	Takeoff Clearance	I	C	I	I	EUC	UT
103001	VMC	TWR	G-G	ATC	Grnd		SMT(2)	Takeoff/Departure Instructions	I	C	I	I	EUC	UT
103105	VMC	TWR	G-G	ATC	Grnd		SMA,SMT	Takeoff/Departure Instructions	I	C	C	I	EVA/RTA	GC,RTG
241011	VMC	CTR	A-A	ATC	Air		SMT,WDB,?	Crossing Restriction	I	C	C	I	FMS	AC

Note: Acronym Key for Header and Table contents is at the end of the table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION				TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT				(CORRECT OR (INCORRECT			LISTENER ACTION	RESULTING INCIDENT
			ENV L-R/T	TR SRC	RCV POS							TR	L INT	L ACT		

Instructional Party Line Elements: Incorrect Transmission, Correct Action																
160299A	VMC	TWR	G-G	ATC	Grnd	WDB,?		Cross Active Runway	I	I	C	C	C	CC		GC
217638A	VMC	TWR	G-G	ATC	Grnd	LTT,MLG		Takeoff Clearance	I	I	C	C	C	EVA/RTA		CA/G
184723	IMC	CTR	A-A	ATC	Air	WDB(2)		Holding Instructions	I	I	C	C	C	QA		CA/A
134748	VMC	CTR	A-A	ATC	Air	MLG,?		Altitude Clearance	I	I	C	C	C	QC		AD
191230	VMC	CTR	A-A	ATC	Air	LGT(2)		Altitude Clearance	I	I	C	C	C	QC		CA/A
100800	VMC	TWR	A-G	ATC	Grnd	SMA,SMT		Takeoff/Departure Instructions	I	I	C	C	C	QC		CA/A
184688B	IMC	APP	A-A	ATC	Air	MLG(2)		Altitude Clearance	I	I	C	C	C	QC		NONE
115584	MXD	TWR	G-G	ATC	Grnd	LGT,WDB		Takeoff/Departure Instructions	I	I	C	C	C	QC		WXA

Instructional Party Line Elements: Incorrect Transmission, Incorrect Action																
187752	VMC	TWR	G-G	ATC	Grnd	SMA(2)		Departure Clearance	I	I	I	I	I	CC		NMAC
109535	IMC	TWR	A-A	ATC	Air	SMA(2)		Heading Clearance	I	I	I	I	I	EUC		HD,AC

Non-Specific Party Line Incidents																
98555								Dual Frequency								
100007								Dual Frequency								
128730								Dual Frequency								
149385								Dual Frequency								
220645								Dual Frequency								
123431								G/S Incident								
142041								U.S. Flights in Foreign Countries								

# ACRONYM KEY

WX COND - Weather Conditions	TR FREQ - Transmitter Frequency	CTR - Center Frequency (ARTCC)	Receiver/Transmitter, respectively
IMC - Instrument Meteorological Conditions	AIR - Airport Frequency, non-controlled	DEP - Departure Frequency	TR SRC - Transmitter Source, Conveyer (ATC or Air/Pilot) of Party Line Information
MXD - Mixed IMC/VMC Conditions	APP - Approach Control Frequency	GND - Ground Frequency	RCV POS - Receiver Position,
VMC - Visual Meteorological Conditions	CTAF - Common Traffic Advisory Frequency, non-controlled	TWR - Tower Frequency	
		AIRCRAFT CONFIGURATION	
		ENV L-R/T - Environment (Air or Ground) of the Listener and	TYPE OF AIRCRAFT
			BMB - Bomber

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION				TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(CORRECT OR (INCORRECT			LISTENER ACTION	RESULTING INCIDENT
			ENV L-R/T	TR	RCV POS	SRC			TR	L INT	L ACT		

**HVT** - Large Transport  
(over 300,000 lbs)  
**LGT** - Large Transport  
(150,001 - 300,000 lbs)  
**LTT** - Light Transport  
(14,501 - 30,000 lbs)  
**MDT** - Medium Transport  
(30,001 - 60,000 lbs)  
**MLG** - Medium Large  
Transport 60,001 -  
150,000 lbs)  
**SMA** - Small Aircraft  
(Less than 5000 lbs)  
**SMT** - Small Transport  
(5001 - 14,500 lbs)  
**WDB** - Wide Body (over  
300,000 lbs)

# PARTY LINE INFORMATIONAL ELEMENT

A general description of  
the PLI element is  
provided along with an  
indication of whether it  
was and Instructional  
(I) or Advisory (A)  
message

# CORRECT OR INCORRECT

Based on the incident  
reports, the correctness  
or incorrectness of the  
following were  
determined:  
**TR** - Transmitted PLI  
Element  
**L INT** - Interpretation  
of the PLI Element  
**L ACT** - Action of the  
Listener

# LISTENER ACTION

**AT** - Aborted Takeoff  
**CC** - Continued  
Clearance  
**EUC** - Executed  
Unauthorized Clearance  
**EVA** - Evasive Action  
**FMS** - Flight Management  
System Programming  
**GAR** - Go Around  
**MA** - Missed Approach  
**QA** - Query Aircraft  
**QC** - Query Controller  
**RC** - Request Clearance  
**RTA** - Runway Traffic  
Avoidance  
**WXA** - Weather Awareness,  
Avoidance

# RESULTING INCIDENT

**AC** - Airborne Conflict  
**AD,HD,TD** - Altitude,  
Heading,Track Deviation,  
**CA/A** - Conflict  
Avoidance/Airborne  
**CA/G** - Conflict  
Avoidance/Ground  
**GC** - Ground Conflict  
**NMAC** - Near Mid-Air  
Collision  
**RTG** - Runway  
Transgression  
**UT** - Unauthorized  
Takeoff  
**WXA** - Weather  
Awareness/Avoidance

APPENDIX B

ASRS FULL FORM REPORTS

The full form reports as received from ASRS are provided in the following appendix. Refer to the following guide for help in locating the various incident reports. NOTE: the reports are numbered sequentially by accession number for each category of incidents.

ADVISORY PLI ELEMENTS: Correct Transmission, Correct Action	B-2
ADVISORY PLI ELEMENTS: Correct Transmission, Incorrect Action	B-33
ADVISORY PLI ELEMENTS: Incorrect Transmission, Correct Action	B-38
ADVISORY PLI ELEMENTS: Incorrect Transmission, Incorrect Action	B-40
INSTRUCT PLI ELEMENTS: Correct Transmission, Correct Action	B-41
INSTRUCT PLI ELEMENTS: Correct Transmission, Incorrect Action	B-69
INSTRUCT PLI ELEMENTS: Incorrect Transmission, Correct Action	B-86
INSTRUCT PLI ELEMENTS: Incorrect Transmission, Incorrect Action	B-95
Non-Specific Party Line Incidents	B-98

**ADVISORY PLI ELEMENTS: Correct Transmission, Correct Action**

ACCESSION NUMBER: 93273  
DATE OF OCCURRENCE: 8808  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; TRACON,AC; FLC, PLT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SLC  
FACILITY STATE: UT  
FACILITY TYPE: TRACON; ARPT;  
FACILITY IDENTIFIER: SLC; SLC;  
AIRCRAFT TYPE: LTT; SMA;  
ANOMALY DESCRIPTIONS: OTHER; NON ADHERENCE LEGAL RQMT/FAR;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; NOT  
RESOLVED/INSUFFICIENT TIME;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: ON IFR FLT PLAN, WE WERE ON APCH ON HIGH  
DOWNWIND LEG AND 5 MI S OF ARPT. FREQ WAS EXTREMELY CONGESTED AS  
CTLR TRNEE, UNDER SUPERVISION, WAS HANDLING 2 FREQS WITH 1  
XMITTER. WE HEARD ATC TELL AN SMA THAT A PARACHUTE JUMP WAS NOT  
AUTHORIZED DUE TO AIRSPACE CONGESTION. WE DID NOT HEAR A REPLY,  
AS THE SMA WAS ON THE OTHER FREQ. AS AN ACR JET PASSED OUR 9  
O'CLOCK ON FINAL TO RWY 34L, WE WERE CLRED FOR A VISUAL APCH TO  
FOLLOW THAT JET. AS WE TURNED BASE LEG, THE CAPT WHO WAS THE PF,  
POINTED OUT AN UNIDENTED ACFT DSNDING OFF OUR RIGHT AND TURNING  
IN OUR GENERAL DIRECTION. HE INITIATED A RAPID DSNT TO AVOID THE  
ACFT, WHICH HAD NOT BEEN POINTED OUT BY ATC. WE LEVELED OUT AT  
7000', STILL ON BASE LEG, WHEN I (F/O) NOTED AN OBJECT AT OUR 10  
O'CLOCK WHICH I FIRST THOUGHT WAS A BALLOON, ABOUT 500' AWAY AND  
SLIGHTLY BELOW US. I THEN LOOKED FORWARD AND SAW 2 PARACHUTES AT  
OUR 12 O'CLOCK AND ABOUT 300' AWAY, DIRECTLY IN OUR DSNT PATH. I  
YELLED SOMETHING ABOUT PARACHUTES AND GRABBED THE YOKE,  
INITIATING A CLBING LEFT TURN. I RELEASED THE CONTROLS AS SOON AS  
I SAW THAT THE CAPT WAS AWARE OF AND HANDLING THE SITUATION. WE  
CONTINUED OUR APCH AND LANDED. CONTRIBUTING FACTORS: SMA PLT  
DROPPED JUMPERS W/O ATC AUTH, WHILE OPERATING IN RESTRICTED  
AIRSPACE. I WAS TOLD BY THE TRACON SUPVR THAT THE PLT, WHEN  
QUESTIONED, ADMITTED SEEING US BELOW HIM BUT THOUGHT THAT THE  
JUMPERS COULD AVOID US. HE ALSO ALLOWED THOSE JUMPERS OUT W/O ANY  
LIGHTING, ALTHOUGH LEGAL SUNSET OCCURRED 23 MINS BEFORE. HE ALSO  
INITIATED A DSNT W/O AUTHORIZATION. ATC--WAY TOO MUCH TFC FOR A  
TRNEE TO BE HANDLING 2 FREQS. ALTHOUGH NOT LEGALLY REQUIRED,  
SINCE THERE WAS AN ASSIGNED ALT DIFFERENCE OF 500', HE DID NOT  
POINT OUT THE SMA. WE NEEDED A POINTOUT THAT AT LEAST WOULD HAVE  
MADE US AWARE OF POTENTIAL TFC AND AVOIDED THE FIRST SURPRISE.  
POSSIBLE SOLUTIONS: ASIDE FROM THE OBVIOUS BAN ON JUMP ACTIVITIES  
DURING HVY ATC ACTIVITY, SO THAT THE ACFT WAS NOT EVEN ALLOWED  
WITHIN 10 MI OF TFC CORRIDORS, THIS PLT'S JUDGEMENT MUST BE  
SUSPECT. FAA SHOULD ALSO VIOLATE THE OPERATOR IF TRNING IN ATC  
PROCS IS FOUND TO BE DEFICIENT. THERE IS NOT EXCUSE FOR THIS SORT  
OF SHODDY OPERATING PRACTICE SO CLOSE TO A MAJOR COMMERCIAL ARPT.

(REPORT CONTINUED)

THE BIGGEST REASON WE DID NOT HIT THOSE JUMPERS WAS PURE LUCK,  
GIVEN THE TIME OF DAY.

SYNOPSIS: ACR LTT, ON FINAL APCH COURSE, HAD VERY CLOSE  
CALL WITH PARACHUTE JUMPERS.

REFERENCE FACILITY ID: SLC

FACILITY STATE: UT

DISTANCE & BEARING FROM REF : 5,,SO

MSL ALTITUDE: 6700,7000

ACCESSION NUMBER: 102190  
DATE OF OCCURRENCE: 8901  
REPORTED BY: FLC;  
PERSONS FUNCTIONS: FLC,PIC.CAPT;  
FLIGHT CONDITIONS: IMC  
REFERENCE FACILITY ID: BTR  
FACILITY STATE: LA  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: BTR; BTR;  
AIRCRAFT TYPE: MLG;  
ANOMALY DESCRIPTIONS: OTHER;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;

NARRATIVE: THE LNDG RWY ON THE ATIS WAS A BACK COURSE LOC 4L WITH INCREASED MINIMA DUE TO CONSTRUCTION. APCH CTL ADVISED WE COULD BE USING THE ILS 22R WITH AN 8 KT TAILWIND DUE TO DETERIORATING WX (RAIN/FOG). AN EXPEDITED DSNT WAS ACCOMPLISHED AND 180 KTS ASSIGNED TO THE OM. WE HAD RWY IN SIGHT AT APPROX 500/1 AND T/D WAS W/O INCIDENT. I BELIEVE WE MAY HAVE BEEN THE FIRST COMMERCIAL ACFT TO LAND AFTER THE RWY CHANGE AND THERE WERE 3 TRAILING JETS ON APCH CTL FREQ. WE WERE CONFIGURED WITH FULL (40 DEG) FLAPS, AUTO BRAKING ARMED AND APCH SPD OF 132 KTS. AT APPROX 80 KTS WITH 2500+' REMAINING, THE AUTO BRAKES WERE DISENGAGED DUE TO POOR DECELERATION. BRAKING ACTION WAS NIL AT THIS POINT AND REVERSE THRUST WAS INCREASED BACK UP TO 1.8 EPR AND KEPT THERE UNTIL BELOW 60 KTS WHEN BRAKING ACTION BECAME ACCEPTABLE. WE USED ALMOST ALL THE AVAILABLE RWY AND ADVISED THE TWR THAT BRAKING ACTION WAS POOR AT BEST. THE NEXT ACFT WAS ALERTED FOR A POSSIBLE GAR AND ACKNOWLEDGED OUR BRAKING ACTION RPT. WE CLRED THE RWY IN SUFFICIENT TIME FOR THAT ACFT TO LAND SAFELY AND HEARD THE NEXT ACFT RECEIVE THE ADVISORY BEFORE CHANGING TO GND CTL. THE FOURTH ACFT WENT OFF THE END SOME 200-300' IN THE MUD. MEANWHILE OUR MOMENTUM PRECLUDED THE HARD 180 DEG TURN ONTO TXWY A AND WE HAD TO USE TXWY C, SO UTILIZING WING WALKERS THROUGH THE GA PARKING AREA.

SYNOPSIS: ACR MLG REPORTED BRAKING POOR AFTER LNDG AT BTR. BRAKING ACTION REPORTED TO NEXT 2 ACFT AND REPORT OVERHEARD BY REPORTER VIA PARTYLINE. FOURTH ACFT IN STRING HAD RWY EXCURSION. SEE ACN 101549 AND 101772.

REFERENCE FACILITY ID: BTR  
FACILITY STATE: LA  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 103715  
DATE OF OCCURRENCE: 8902  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID: EWR  
FACILITY STATE: NJ  
FACILITY TYPE: TWR; ARPT;  
FACILITY IDENTIFIER: EWR; EWR;  
AIRCRAFT TYPE: WDB;  
ANOMALY DESCRIPTIONS: OTHER; NO SPECIFIC ANOMALY OCCURRED;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/ANOMALY ACCEPTED; NOT  
RESOLVED/DETECTED AFTER-THE-FACT;

ANOMALY CONSEQUENCES: NONE;

NARRATIVE: TAXIING OUT TO TKOF AT EWR ATIS CALLING WX  
CLEAR, GOOD VSBLTY, WINDS 310/18 KTS. TWR CALLING WINDS 310/19  
KTS. COMMENCED TKOF ON RWY 22R. ON TKOF ROLL WE OVERHEARD TWR  
GIVE ANOTHER ACFT THE WINDS OF 300 TO 310 AT 19 KTS GUSTING TO  
30-33 KTS. THIS GUST FACTOR WAS NEVER GIVEN TO US. THUS, WE MADE  
A TKOF WITH RPTED CROSSWINDS THAT WERE MUCH HIGHER THAN WE  
ANTICIPATED, AND CROSSWINDS THAT WERE CLOSE TO THE LIMITING  
CROSSWINDS OF THE ACFT. THE TKOF WAS NORMAL AND NO SIGNIFICANT  
WINDS WERE ENCOUNTERED, BUT IT WOULD HAVE BEEN APPROPRIATED THAT  
WE BE ADVISED OF THESE SIGNIFICANT GUST FACTORS.

SYNOPSIS: WDB OVERHEARD TWR GIVE WIND GUST INFORMATION TO  
ANOTHER ACFT WHILE WDB WAS ON TKOF ROLL. REPORTER COMPLAINT THAT  
HE WAS NOT GIVEN THE GUST INFORMATION.

REFERENCE FACILITY ID: EWR  
FACILITY STATE: NJ  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 105191  
 DATE OF OCCURRENCE: 8902  
 REPORTED BY: FLC; ;  
 PERSONS FUNCTIONS: FLC,PLT; FLC,PIC.CAPT;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:PIB  
 FACILITY STATE: MS  
 FACILITY TYPE: ARPT;  
 FACILITY IDENTIFIER: PIB;  
 AIRCRAFT TYPE: ; ;  
 ANOMALY DESCRIPTIONS: UNCTRLED ARPT TRAFFIC PATTERN DEVIATION;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: OTHER;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: I WAS APCHING THE ARPT IN VFR CONDITIONS AND HAD  
 RECEIVED UNICOM ARPT ADVISORY. APCH WAS FROM THE N AFTER  
 CANCELLING IFR. I WAS ADVISED BY ATC THAT AN ACFT WAS IN TRAIL BY  
 APPROX 2 TOUR MILES AND AT A HIGHER ALT. I THEN ENTERED THE LEFT  
 HAND TFC PATTERN ON THE DOWNWIND AND AS BASE LEG WAS BEING  
 TURNED. A AIRLINER ACFT CALLED FINAL. I OBSERVED WHAT I BELIEVE  
 TO BE THAT ACFT WHICH HAD BEEN BEHIND ME ON AN APPROX 4 MI FINAL.  
 I ANNOUNCED TURNING BASE AND REQUESTED THE OTHER ACFT TO "SAY  
 POS." HE THEN ANNOUNCED THAT HE WOULD BE CROSSING OVER THE FIELD  
 AND ENTERING DOWNWIND (WHICH HE SHOULD HAVE DONE THE FIRST TIME).  
 I REALIZE THAT SCHEDULED CARRIERS HAVE LARGE COSTS INVOLVED BUT  
 SHOULD BE REQUIRED TO COMPLY WITH TFC PATTERNS AT UNCONTROLLED  
 FIELDS.  
 SYNOPSIS: ACR ACFT MADE IMPROPER TRAFFIC PATTERN ENTRY.  
 REFERENCE FACILITY ID:PIB  
 FACILITY STATE: MS  
 DISTANCE & BEARING FROM REF: 3,,N  
 AGL ALTITUDE: 1000,1000

ACCESSION NUMBER: 121920  
 DATE OF OCCURRENCE: 8909  
 REPORTED BY: FLC; ;  
 PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:TRK  
 FACILITY STATE: CA  
 FACILITY TYPE: ARPT; ARPT;  
 FACILITY IDENTIFIER: TRK; TRK;  
 AIRCRAFT TYPE: SMA; SMA;  
 ANOMALY DESCRIPTIONS: CONFLICT/NMAC; ACFT EQUIPMENT PROBLEM/CRITICAL;  
 UNCTRLED ARPT TRAFFIC PATTERN DEVIATION; NON ADHERENCE LEGAL  
 RQMT/PUBLISHED PROC;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; NOT  
 RESOLVED/UNABLE;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: CALLED UNICOM AND WAS TOLD THE WINDS WERE  
 SQUIRRELY BUT FAVORING RWY 28. AT THE E END OF DONNER LAKE, I  
 CALLED TRUCKEE TFC TO ANNOUNCE A 45 DEG ENTRY TO LEFT TFC FOR RWY  
 28. I HEARD THE GLIDER TOWPLANE (ON RIGHT DOWNWIND FOR 19) AND  
 ANOTHER AIRPLANE (ON LEFT DOWNWIND FOR 10) TRYING TO WORK OUT A  
 DANGEROUS CONFLICT IN THEIR PATTERNS. ALSO, AN ACFT REPORTED HIS  
 POSITION NEAR SQUAW VOR WITH INTENTIONS OF FLYING THE LAKESHORE  
 (TAHOE) FOR A LEFT BASE ENTRY INTO RWY 28. I ANNOUNCED DOWNWIND  
 LEFT FOR 28 AND WAS WATCHING THE 10 TFC TURN FINAL. I THEN  
 STARTED LOOKING FOR TFC FROM THE "LAKE" WHEN I NOTICED AN SMA  
 TWIN STARTING TO TAKE OFF ON 28 DIRECTLY OPPOSING THE LNDG ACFT N  
 10. I ANNOUNCED THE SITUATION ON THE RADIO AND THE SMA TWIN MADE  
 A TURN OFF THE RWY BACK TO THE HOLDING AREA. I TURNED TO FINAL  
 AND ANNOUNCED "TURNING FINAL 28 TRUCKEE." WHILE ON SHORT FINAL,  
 THE ACFT PULLS OUT IN FRONT OF ME AND PROCEEDS TO TAKE OFF. I  
 DIVERTED MY PLANE WELL TO THE RIGHT OF CENTERLINE. AFTER THE ACFT  
 HAD PASSED ME I TURNED TO REENTER THE PATTERN. THERE WAS AN SMA Y  
 ENTERING THE PATTERN AND WE BOTH REPORTED ENTERING DOWNWIND  
 SIMULTANEOUSLY. HE WAS AHEAD OF ME SO I REPORTED BEING #2 FOR 28.  
 AS I PASSED THE 28 NUMBERS, MY ENGINE STOPPED RUNNING. I SWITCHED  
 TANKS AND THE ENGINE STILL WOULD NOT RUN. I INFORMED THE SMA Y I  
 WAS EXPERIENCING ENGINE TROUBLE AND WOULD LAND AHEAD OF HIM. THE  
 TXWY WAS CLEAR SO I ELECTED TO LAND ON THE TXWY. INSPECTION OF MY  
 ACFT REVEALED THAT THE FUEL LINE FROM THE GASCOLATOR TO THE  
 CARBURETOR WAS DEFECTIVE CAUSING A BLOCKAGE OF FUEL TO THE  
 CARBURETOR.  
 SYNOPSIS: CLOSE PROX GA-SMA GA-SMA TWIN AT NON TWR ARPT.  
 REFERENCE FACILITY ID:TRK  
 FACILITY STATE: CA  
 DISTANCE & BEARING FROM REF.: 2,,SO  
 MSL ALTITUDE: 5900,5900

ACCESSION NUMBER: 133393  
DATE OF OCCURRENCE: 9001  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT; TRACON,AC;  
FLIGHT CONDITIONS: MXD  
REFERENCE FACILITY ID:CEW  
FACILITY STATE: FL  
FACILITY TYPE: TRACON; ARPT;  
FACILITY IDENTIFIER: VPS; CEW;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL  
SEPARATION; OTHER;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;

NARRATIVE: I WAS AT 4500' INBND TO CEW VFR ON TOP OF CLOUDS. AS I GOT WITHIN ABOUT 25 MI OF CEW THE CLOUDS WENT FROM SCATTERED TO BROKEN, TO SOLID, WITH TOPS AT ABOUT 2500'. I CALLED CEW FSS AND LEARNED THAT CEW WAS 1000' OVERCAST, VSBLTY 5 MI. I DECIDED THAT THE SAFEST AND BEST COURSE WAS TO REQUEST AN IFR APCH RATHER THAN SEARCH FOR A HOLD TO DSND THROUGH. I CALLED EGLIN APCH AND REQUESTED (I THOUGHT) AN IFR LOCALIZER APCH TO RWY 17 AT CEW. THE EGLIN CTLR CAME RIGHT BACK WITH "SQUAWK...CLEARED TO KOBRA, CLEARED FOR THE LOCALIZER 17 APCH. CRESTVIEW USING RWY 35, MAINTAIN 2200 UNTIL KOBRA OUTBND". I ROGERED THE CLRNC AND REPORTED LEAVING 4500'. UPON REACHING KOBRA I REPORTED "MY ID X, KOBRA OUTBND, LEAVING 2200". ABOUT A MIN LATER, WHILE IN THE APCH AND IN IMC CONDITIONS, I HEARD SMA Y CALL APCH AND REQUEST THE VOR-A APCH TO CRESTVIEW, AND STATE HIS INTENTIONS THAT UPON REACHING VMC HE WOULD CANCEL AND CONTINUE VFR TO DEFUNIAK SPRINGS, A NEARBY VFR ARPT. THIS CAUSED ME TO WONDER IF SMA Y AND I WOULD CONVERGE IN IMC (THE APCHES CONVERGE) SO, THOUGH IT WAS NOT REQUESTED, I REPORTED "PROC TURN INBND". TO MY AMAZEMENT THE CTLR ANSWERED "ROBERT X MAINTAIN VFR!" I THEN SAID "BUT I'M NOT VFR, I'M IN THE CLOUDS". THE CTLR THEN REPLIED "ROGER X, CLIMB TO 2200' HOLD AS PUBLISHED AT KOBRA, YOU'RE #2 FOR APCH!" I THEN SAID "BUT I'M ONLY 1 MI OUTSIDE THE MARKER AT 1500." AS I TURNED OUTBND IN HOLDING, EGLIN APCH CLEARED ME FOR AN IFR APCH TO CEW. UPON LNDG I CALLED THE EGLIN WATCH SUPVR AND WE AGREED THERE WAS A DISCONNECT BETWEEN ME AND THE CTLR. I THOUGHT I WAS ON AN IFR CLRNC AND THE CTLR THOUGHT I WAS CONDUCTING THE APCH IN VFR CONDITIONS FOR TRAINING/PROFICIENCY. I DON'T THINK I CAME CLOSE TO SMA Y.

SYNOPSIS: LESS THAN STANDARD SEPARATION BETWEEN 2 SMA ACFT MAKING DIFFERENT IFR APCHES TO SAME ARPT. OPERATIONAL ERROR OR PLT DEVIATION.

REFERENCE FACILITY ID:CEW  
FACILITY STATE: FL  
DISTANCE & BEARING FROM REF.: 5,350  
MSL ALTITUDE: 1500,2200

ACCESSION NUMBER: 141056  
 DATE OF OCCURRENCE: 9003  
 REPORTED BY: FLC; ;  
 PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:BLD  
 FACILITY STATE: NV  
 FACILITY TYPE: ARPT;  
 FACILITY IDENTIFIER: BLD;  
 AIRCRAFT TYPE: SMA; SMA;  
 ANOMALY DESCRIPTIONS: CONFLICT/NMAC; UNCTRLED ARPT TRAFFIC PATTERN  
 DEVIATION;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
 ANOMALY CONSEQUENCES: OTHER;  
 NARRATIVE: RETURNING FROM A GRAND CANYON SCENIC FLT, I  
 RPTED TURNING AROUND THE HOOVER DAM AT 3500', SWITCHING TO BLD  
 UNICOM. I SWITCHED FROM 123.05 TO 122.7 (BLD UNICOM) AND DSNDDED  
 TO 3200' AND RPTED COMING UP ON GOLD STRIKE CASINO. SHORTLY  
 AFTER, A HELI APPEARED IN FRONT OF ME. I PULLED THE NOSE OF MY  
 ACFT UP TO AVOID THE HELI. I FIRST SAW THE PLANE OF THE ROTOR  
 BLADES PAINTED BLACK AND WHITE. THE FRONT SEAT PAX AND I SAW THE  
 HELI AT THE SAME INSTANT AND MY REACTION WAS INSTANTANEOUS. I  
 SPOKE TO THE HELI PLT RIGHT AWAY AND WE HAD BOTH RPTED THE GOLD  
 STRIKE CASINO BUT ON DIFFERENT FREQS. I HAD HEARD THE HELI RPT AT  
 A DIFFERENT LOCATION EARLIER AND WAS AWARE OF HIS PRESENCE AND  
 WATCHING FOR HIM. HE TURNED OUT TO BE JUST BELOW MY LINE OF SIGHT  
 AND WAS DIFFICULT TO SEE. TO PREVENT A RECURRENCE, WE WILL PLAN  
 ON STAYING AT 3500' UNTIL PAST OUR CHKPOINT. WE WILL GO S OF THE  
 CHKPOINT WHILE HELI WILL GO N. HOPEFULLY THIS WITH INCREASED  
 AWARENESS WILL STOP ANYTHING LIKE THIS HAPPENING AGAIN.  
 SYNOPSIS: CLOSE PROX CHARTER SMA HELI ENTERING TRAFFIC  
 PATTERN AT NON TWR ARPT.  
 REFERENCE FACILITY ID:BLD  
 FACILITY STATE: NV  
 DISTANCE & BEARING FROM REF.: 5,,NE  
 MSL ALTITUDE: 3200,3500

ACCESSION NUMBER: 142110  
DATE OF OCCURRENCE: 9004  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PLT; TWR,GC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:LIH  
FACILITY STATE: HI  
FACILITY TYPE: TWR; ARPT;  
FACILITY IDENTIFIER: LIH; LIH;  
AIRCRAFT TYPE: MLG; SMT;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; RWY  
TRANSGRESS/OTHER;  
ANOMALY DETECTOR: OTHER; COCKPIT/FLC; ATC/CTLR;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; CTLR ISSUED NEW  
CLNC; FLC EXECUTED GAR OR MAP;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: AS WE TAXIED FOR TKOF AT RWY 3 AT LIH, LIH GND  
TOLD US TO TAXI INTO POS AND HOLD, MAKE LIH 5 DEP, AND MONITOR  
THE TWR. AS WE PULLED ONTO RWY 3 (3 AND 35 WERE ACTIVE), WE HEARD  
AN ACFT ASK TWR IF THE MLG WAS GOING INTO POS. I LOOKED BACK TO  
MY 5 O'CLOCK POS TO SEE AN SMT ON A CLOSE-IN BASE. WE IMMEDIATELY  
CLRED THE RWY AS THE TWR TOLD THE SMT TO GO AROUND. WE  
IMMEDIATELY TOLD THE TWR WE HEARD WE WERE CLRED INTO POS. HIS  
REPLY WAS, "WELL, I GUESS YOU HEARD WRONG." IT'S COMMON PRACTICE  
AT THIS TWR TO HAVE THE LCL CTLR WORKING BOTH TWR AND GND FREQS.  
W/O MAKING ASSUMPTIONS, THERE WERE 3 AIRLINES INBND FOR RWY 35--2  
ON THE GND, 1 ABOUT TO BACK-TAXI ON OUR RWY--THAT WE COULD  
MONITOR VISUALLY. THE LIGHT ACFT WAS ON LEFT BASE FOR RWY 3. WE  
COULD NEITHER SEE NOR HEAR UNTIL MONITORING TWR. A CONTRIBUTING  
FACTOR IS CERTAINLY 1 CTLR WORKING 2 FREQS SO THAT WE WERE NOT  
TOTALLY AWARE OF THE TFC SITUATION. ONE OF OUR COMPANY ACFT WAS  
ON FINAL APCH AT THIS TIME, HEARING BOTH GND AND TWR, AND STATED  
HE HEARD US CLRED INTO POS.

SYNOPSIS: ACR MLG TAXIES ONTO ACTIVE RWY INTO PATH OF SMT  
ON APCH.

REFERENCE FACILITY ID:LIH  
FACILITY STATE: HI  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 142920  
DATE OF OCCURRENCE: 9004  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,PIC.CAPT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:EWR  
FACILITY STATE: NJ  
FACILITY TYPE: TWR;  
FACILITY IDENTIFIER: EWR;  
AIRCRAFT TYPE: LRG; LRG;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; FLC EXECUTED GAR  
OR MAP;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: ACR X TKOF WAS BEING MADE ON RWY 4R AT EWR. ACR  
Y HAD PREVIOUSLY BEEN CLRED TO LAND ON RWY 29 AT SAME ARPT. THE 2  
DESCRIBED RWYS DO NOT INTERSECT, SO NO PROB WAS ANTICIPATED. ALL  
MEMBERS OF THE CREW WERE AWARE OF AND MONITORING THE DEVELOPMENT  
OF THE SITUATION. THE TKOF WAS CONTINUED. JUST AFTER LIFTOFF ACR  
Y ANNOUNCED HE WAS GOING AROUND. AT 150' OF ALT, BOTH ACFT MADE  
STEEP LEFT TURN TO AVOID EACH OTHER.  
SYNOPSIS: ACR X HAD AIRBORNE CONFLICT LESS SEVERE WITH ACR  
Y IN ATA.  
REFERENCE FACILITY ID:EWR  
FACILITY STATE: NJ  
DISTANCE & BEARING FROM REF.: 0  
MSL ALTITUDE: 150,150

ACCESSION NUMBER: 149017  
DATE OF OCCURRENCE: 9006  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; TRACON,AC; TWR,LC;  
FLIGHT CONDITIONS: MXD  
REFERENCE FACILITY ID:HPN  
FACILITY STATE: NY  
FACILITY TYPE: ARPT; TRACON; TWR;  
FACILITY IDENTIFIER: HPN; N90; HPN;  
AIRCRAFT TYPE: SMA;  
ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/WX; OTHER;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;  
ANOMALY CONSEQUENCES: NONE;  
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;

NARRATIVE: I WAS THE PLT OF AN ACFT WITH PAX, RETURNING TO WESTCHESTER COUNTY ARPT FROM THE PHILADELPHIA AREA. BEFORE DEPARTING, I RECEIVED A WX BRIEFING WHICH INDICATED THAT THE WX AT WESTCHESTER COUNTY ARPT WAS, AMONG OTHER THINGS, SCATTERED CLOUDS AT 4000', VSBLTY 6 MI. WHILE NAVIGATING BTWN THE SOLBERG VOR AND THE SPARTA VOR, I OBSERVED THAT THE WX WAS BEGINNING TO BECOME LESS THAN THAT RPTED FOR WESTCHESTER COUNTY ARPT. CLOUDS WERE LOWERING AND THE VSBLTY WAS APPROX 3 MI. ON REACHING THE SPARTA VOR, I WAS MONITORING NY APCH ON FREQ 126.40. ANOTHER ACFT CONTACTED NY APCH AND REQUESTED VECTORS FOR AN ILS APCH TO RWY 16 AT W. THE CTLR RESPONDED, "WHY WOULD YOU WANT AN ILS APCH?" THE PLT RESPONDED, "VSBLTY IS VERY POOR AND I CAN'T SEE THE ARPT." I WAS ALSO MONITORING THE WESTCHESTER ATIS, WHICH WAS RPTING SCATTERED CLOUDS AT 4000' VSBLTY 6 MI. THE CTLR THEN RESPONDED TO THE PREVIOUS PLT'S REQUEST FOR AN ILS APCH INTO RWY 16 BY SAYING THAT HE WAS PROBABLY IN A LCL SQUALL OR CLOUD BUT WOULD GIVE HIM VECTORS TOWARD THE ARPT. APPROX 15 MI W OF WESTCHESTER COUNTY ARPT, THE CTLR ASSIGNED ME A XPONDER CODE AND TOLD ME TO PROCEED FOR A STRAIGHT IN APCH TO RWY 11. I WAS OVER THE TAPPEN ZEE BRIDGE AND WAS UNABLE TO SEE IT BECAUSE OF LOW CLOUDS AND POOR VSBLTY. I DECLINED RWY 11 AND REQUESTED AN ILS APCH TO RWY 16. HE COMPLIED AND VECTORED ME TO THE N. WHILE MONITORING THE APCH FREQ, I HEARD SEVERAL OTHER PLTS CALL IN AND ASK FOR WX AT WESTCHESTER COUNTY ARPT AND WHETHER IT WAS STILL VFR. THE APCH CTLR REPLIED WITH THE SAME INFO THAT THE ATIS WAS PROVIDING. HE STATED AFFIRMATIVELY THAT WESTCHESTER COUNTY ARPT WAS STILL VFR. THERE WAS NO MENTION TO THESE PLTS CALLING IN THAT OTHER PLTS HAD PREVIOUSLY RPTED THE CONDITIONS TO BE LESS FAVORABLE THAN STATED ON THE ATIS, NOR DID HE RPT THE OTHER PLTS HAD REQUESTED VECTORS FOR THEE ILS APCH BECAUSE OF POOR VSBLTY. THE APCH CTLR FINALLY RETURNED TO ME AND GAVE ME VECTORS TOWARD AN E DIRECTION, BUT DID NOT VECTOR ME S UNTIL I HAD PASSED THE EXTENDED CENTERLINE OF RWY 16. I RECEIVED VECTORS BACK TO INTERCEPT THE LOC AND G/S. WHILE ON THE LOC AND G/S, WE FLEW THE APCH DOWN TO 800' BEFORE BARELY SEEING THE APCH LIGHTS FOR RWY 16. I WAS SWITCHED OVER TO THE TWR AT THAT POINT AND RPTED THAT THE VSBLTY APPEARED TO BE APPROX 1 MI AND THAT THE ARPT WAS NOT VISIBLE ABOVE 800'. THE TWR CTLR STATED THAT THE ATIS RPT WAS BEING CHANGED. ON THIS PARTICULAR OCCASION, I FEEL THAT THERE WAS A FAILURE ON THE PART OF THE APCH

(REPORT CONTINUED)

CTLR TO UNDERSTAND AND INTERPRET THE RPTS HE WAS RECEIVING FROM PLTS IN THE AREA AND TO RELAY THESE RPTS TO OTHER PLTS CALLING IN. IN ADDITION, THERE APPEARED TO BE NO COORD BTWN THE TWR AND PACH CTL, INsofar AS WX CONDITIONS WERE CONCERNED. PLT CALLING IN TO APCH WERE ADVISED THAT WESTCHESTER WAS STILL VFR WHEN, IN FACT, IT WAS IFR. A PLT WHO WAS NOT INS RATED OR QUALIFIED RELAYING UPON THESE ERRONEOUS RPTS, WOULD QUICKLY FIND HIMSELF IN CONDITIONS ABOVE HIS CAPABILITIES. IF THE PLT OF THE SMA WHICH CRASHED INTO RYE LAKE ON 6/THU/90 WAS NOT INS RATED, AND RELIED UPON THE RPTS GIVEN BY THE APCH CTLR, THEN THE CAUSE OF THE DISASTEROUS RESULTS IS READILY APPARENT. I BELIEVE THAT THE SAFETY FACTOR SOUGHT TO BE ACHIEVED BY THE ATC SYS FALLS FAR SHORT OF ITS MARK WHEN THE APCH CTLR FAILS OR REFUSES TO PASS ON TO PLTS PIREPS WHICH COMPLETELY CONTRADICT PUBLISHED ATIS RPTS OF VFR WX AND IN SO DOING MISLEAD PLTS INTO PROCEEDING TOWARD AN AREA WHERE THYE HAVE NO BUSINESS BEING.

SYNOPSIS: GA SMA PLT THINKS HE AND OTHER GA PLTS WERE LED UP THE GARDEN PATH BY N90 WHEN APCH CTLR FAILED TO FORWARD PLT WX REPORTS AND CONTINUED TO GIVE OUTDATED ATIS WX. HPN TWR SLOW TO UPDATE DETERIORATING WX ON ATIS.

REFERENCE FACILITY ID:HPN

FACILITY STATE: NY

DISTANCE & BEARING FROM REF.: , ,SW

MSL ALTITUDE: 2500,2500

ACCESSION NUMBER: 151548  
DATE OF OCCURRENCE: 9007  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:PRC  
FACILITY STATE: AZ  
FACILITY TYPE: TWR; ARPT;  
FACILITY IDENTIFIER: PRC; PRC;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; OTHER;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: I WAS IN A PART 141 PLANE IN R CLOSE TRAFFIC FOR  
RWY 21. I HEARD ANOTHER PLANE, SMA Y CALLING A 5 MI 45 ENTRY TO  
DOWNWIND. I LOOKED BUT COULD NOT PICK UP UNTIL HE CALLED A 2 MI  
45 DEG. AT THAT POINT I SAW HIS POS WAS NOT MOVING ACROSS A POINT  
ON MY WINDSCREEN. I ROLLED MY WINGS THEN ATTEMPTED A CALL TO THE  
TWR TO TELL MY POS. AS I BECAME AWARE THAT THE 45 DEG TFC SMA Y  
DID NOT SEE ME I CALLED HIS NUMBER AND TOLD MY POS OVER TWR FREQ.  
AS BEFORE, I GOT STEPPED ON BY OTHER CALLS, AS I FOUND OUT LATER.  
AT THIS POINT, I DSNDED 200' BELOW TFC PATTERN ALT AS HE PASSED  
OVER THE TOP OF ME. THEN HE BECAME AWARE OF ME AND WIDENED OUT  
HIS DOWNWIND. TWR THEN ASKED HIM IF HE HAD ME IN SIGHT. I TALKED  
TO THE OTHER PLT ON THE GND AND WE AGREED THAT IF I HAD NOT  
DSNDED WE WOULD HAVE COLLIDED. THIS IS THE STANDARD WAY TO ENTER  
THE PATTERN. WE BOTH FEEL THAT ATC MIGHT HAVE ADVISED US EACH  
THAT ANOTHER PLANE WAS IN THE AREA.

SYNOPSIS: NMAC BETWEEN 2 SMA'S IN TRAFFIC PATTERN AT PRC.  
REFERENCE FACILITY ID:PRC  
FACILITY STATE: AZ  
MSL ALTITUDE: 800,1000

ACCESSION NUMBER: 151948  
DATE OF OCCURRENCE: 9007  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:FTG  
FACILITY STATE: CO  
FACILITY TYPE: ARPT;  
FACILITY IDENTIFIER: FTG;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: OTHER; UNCTRLED ARPT TRAFFIC PATTERN DEVIATION;  
CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC; NON  
ADHERENCE LEGAL RQMT/FAR;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: OTHER;  
NARRATIVE: I ENTERED DOWNWIND ON A 45. I MADE ALL RADIO  
CALLS, DOWNWIND, BASE AND FINAL.L ON 1/4 MI FINAL, A CIVIL AIR  
PATROL SMA CALLED FINAL. I LOOKED BEHIND ME AND DID NOT SEE HIM.  
I THEN SAW HIM JUST ABOVE ME. I TOOK EVASIVE ACTION AND INFORMED  
HIM I WAS BELOW. HE GOT ABUSIVE ON THE RADIO, THEN TOOK EVASIVE  
ACTION. THERE WAS A DISCUSSION ON THE GND BTWN MYSELF AND THE  
OTHER PLT. I TALKED TO THE FAA, AND WAS TOLD ABOUT THE PROCS OF  
AN INVESTIGATION. THE OTHER PLT HAS SEVERAL ACCIDENTS. THOUGH  
I'VE NEVER BEEN IN TROUBLE, I CANNOT AFFORD AN INVESTIGATION DUE  
TO AN UPCOMING CLASS DATE WITH A MAJOR. I DON'T BELIEVE THAT I  
WAS IN THE WRONG.  
SYNOPSIS: CLOSE PROX 2 GA SMA ACFT AT NON TWR ARPT CTAF.  
REFERENCE FACILITY ID:FTG  
FACILITY STATE: CO  
AGL ALTITUDE: 100,250

ACCESSION NUMBER: 153480  
 DATE OF OCCURRENCE: 9008  
 REPORTED BY: FLC; FLC; ; ; ;  
 PERSONS FUNCTIONS: FLC,ISTR; FLC,ISTR; FLC,TRNEE; FLC, TRNEE;  
 TWR,LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:DRK  
 FACILITY STATE: AZ  
 FACILITY TYPE: ARPT; TWR;  
 FACILITY IDENTIFIER: PRC; PRC;  
 AIRCRAFT TYPE: SMA; SMA;  
 ANOMALY DESCRIPTIONS: CONFLICT/NMAC;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
 ANOMALY CONSEQUENCES: NONE;  
 SITUATION REPORT SUBJECTS: PHYSICAL FACILITY/ATC;  
 NARRATIVE: 2 FBO SMA WERE EXECUTING THE VOR RWY 11 APCH AT  
 THE SAME TIME. BOTH ACFT WERE EXECUTING THE APCH IN VFR  
 CONDITIONS W/O IFR SEP AND W/O RADAR. BOTH ACFT WOUND UP AT THE  
 DME ARC AT THE SAME TIME, RESULTING IN A NEAR MISS (WITHIN 50'  
 VERT SEP). TWR DID NOT ADVISE ACFT POS TO EITHER ACFT. INCIDENT  
 COULD HAVE BEEN PREVENTED IF TWR HAD RADAR. SUPPLEMENTAL INFO  
 FROM ACN 153814: AS WE TURNED ON 10 DME ARC ANOTHER ACFT RPTED ON  
 THE ARC. I IMMEDIATELY EXECUTED A CLBING RIGHT TURN AND GOT OFF  
 THE ARC. COULD HAVE BEEN AVOIDED IF WE HAD RADAR. VERY BUSY ARPT  
 WITH HIGH INTENSITY FLT TRNING!  
 SYNOPSIS: CLOSE PROX 2 GA SMA TRAINING ACFT STARTING A DME  
 ARC APCH TO PRC.  
 REFERENCE FACILITY ID:DRK  
 FACILITY STATE: AZ  
 DISTANCE & BEARING FROM REF.: 10,349  
 MSL ALTITUDE: 9000,9000

ACCESSION NUMBER: 157890  
 DATE OF OCCURRENCE: 9009  
 REPORTED BY: CTLR; CTLR; ; FLC;  
 PERSONS FUNCTIONS: TWR,LC; TWR,GC; FLC,PLT; FLC,FO;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:LNS  
 FACILITY STATE: PA  
 FACILITY TYPE: TWR; ARPT;  
 FACILITY IDENTIFIER: LNS; LNS;  
 AIRCRAFT TYPE: SMA; MDT;  
 ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; LESS THAN LEGAL  
 SEPARATION; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;  
 ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
 ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
 ANOMALY CONSEQUENCES: FLC/ATC REVIEW;

NARRATIVE: I WAS WORKING LCL CTL ON A W OPERATION, RWY 31  
 AND 26, TFC WAS MODERATE, NO RESTRICTIONS TO VSBLTY, VFR AND IFR  
 MIX OF TFC. I WAS ON POS FOR JUST OVER ONE HR. GND CTL REQUESTED  
 RWY 31 XING AT BRAVO TXWY, WHICH I APPROVED. AT THS TIME A SINGLE  
 ENG SMA WAS ALREADY FOR TKOF ROLL JUST PASSING THE INTXN AT  
 BRAVO, WHICH IS 1000' DOWN THE RWY, THE NEXT VFR DEP ON RWY 31  
 WAS TAXIED INTO POS HOLD, FOR THE RWY XING AND FOR THE REQUIRED  
 RWY SEP WITH THE SMA DEP. THE ACFT WAS SMA X, A BI-PLANE. I THEN  
 BEGAN TO MOVE TO OTHER DUTIES THAT NEEDED TO BE RESOLVED,  
 SEQUENCE TFC PATTERN, THERE WERE NUMEROUS ARRS INTO THE PATTERN,  
 AN OPP DIRECTION LOW APCH TO RWY 8, AND TFC ADVISORIES BTWN DEPS  
 AND ARRS. I THEN OBSERVED THE SMA DEP OVER THE DEP END OF RWY 31.  
 I BACK SCANNED THE RWY FROM DEP END TO THE ARR END AND THEN TO  
 THE FINAL, I DIDN'T SEE ANY TFC ON THE RWY, NOR DID I SEE THE  
 ACFT ON BRAVO TXWY. AT THAT POINT, I HAD EITHER FORGOTTEN ABOUT  
 THE RWY XING OR THOUGHT IT WAS COMPLETED. SMA X WAS ISSUED TKOF  
 CLRNC. I STARTED TO PUT THE NEXT ACFT INTO POS HOLD WHEN I  
 OBSERVED ACR Y ENTERING THE RWY ENVIRONMENT AT BRAVO. SMA X  
 LIFTED OFF THE RWY AND OVER FLEW ACR Y BY SOME 10-15'. EVASIVE  
 ACTION WAS REQUIRED OF SMA X. ABOUT AN HR LATER SMA X PLT CAME TO  
 THE CTL TWR, IN TAKING WITH HIM, HE SAW ACR Y ON BRAVO TXWY OFF  
 TO HIS L SIDE, HE THOUGHT ACR Y WAS HOLDING SHORT. SMA X IS A  
 TAIL DRAGGER, AND THE PLT SITS IN AN OPEN COCKPIT IN THE BACK OF  
 THE PLANE, HE COULDN'T SEE IN FRONT OF HIS ACFT, HE REALIZED  
 SOMETHING WAS WRONG WHEN MY NEXT XMISSION TO THE NEXT ACFT FOR  
 DEP WAS INTERRUPTED WITH DESPERATION TO BRING THE SITUATION TO  
 HIS ATTENTION, HE LOOKED L AND SAW ACR Y WAS ENTERING THE RWY AND  
 STARTED HIS CLB OUT. IN LOOKING BACK AT HOW THIS COULD HAVE BEEN  
 AVOIDED, I SHOULD HAVE SCANNED THE RWY WITH MORE CONVICTION  
 ESPECIALLY IF TFC WAS AT A MODERATE LEVEL. WHEN I TAXIED SMA X  
 INTO POS AND HOLD, I SHOULD HAVE TOLD HIM WHY, THIS WOULD HAVE  
 ALERTED HIM THAT AN ACFT WAS XING, AND MAY NOT HAVE STARTED HIS  
 TKOF ROLL. IT ALSO MAY HAVE STUCK IN MY HEAD THAT A XING WAS IN  
 THE PROCESS, REGARDLESS IF THE RWY WAS CLR. SUPPLEMENTAL INFO  
 FROM ACN 158307. I ADVISED ACR Y TFC HOLDING, CROSS RWY 31. AT  
 THAT TIME ANOTHER ACFT CALLED AND MY ATTENTION WAS DIVERTED. WHEN  
 I CHKED BACK TO SEE HOW ACR Y WAS PROGRESSING, I SAW SMA X IN A  
 STEEP CLB OVER ACR Y. (THE INTXN IS ONLY ABOUT 800' FROM THE  
 BEGINNING OF THE RWY). SUPPLEMENTAL INFO FROM ACN 157275. WE WERE

(REPORT CONTINUED)

GIVEN CLRNC FROM GND CTL TO TAXI (FROM THE TERMINAL) TO BRAVO HOLD SHORT OF RWY 31. AS WE CAME UPON THE BRAVO HOLD LINE, GND CTL ISSUED US CLRNC TO CROSS RWY 31 AND TAXI TO RWY 26. THERE WAS A TAILWHEEL AIRPLANE (SMA X) HOLDING IN POS ON RWY 31. AS WE BEGAN TO CROSS THE RWY THE CAPT NOTICED THE PROP OF SMA X SPINNING UP. BY THIS TIME SMA X WAS ROLLING TOWARDS US AS WE WERE NOW IN THE MIDDLE OF THE RWY. SMA X ROTATED AND JUST MISSED OUR TAIL. THE CAPT TALKED ON THE PHONE WITH THE SUPVR OF THE TWR TO DISCUSS THE SITUATION. FROM WHAT I UNDERSTAND, SMA X WAS GIVEN TKOF CLRNC RIGHT ABOUT THE TIME WE WERE XING THE RWY. THE CTLR ADMITTED THERE WAS A COMS ERROR IN THE TWR BTWN 2 CTLRS. MY FEELINGS ARE THERE MUST BE AN INCREASED AWARENESS OF BETTER COM SKILLS NEEDED TO PREVENT A SITUATION SUCH AS THIS THAT COULD HAVE BEEN A SERIOUS ACCIDENT.

SYNOPSIS: ACFT WAS CLEARED ACROSS RWY WHILE ANOTHER ACFT WAS CLEARED FOR TKOF. DEP ACFT FLEW OVER CROSSING ACFT.

REFERENCE FACILITY ID:LNS

FACILITY STATE: PA

AGL ALTITUDE: 0,50

ACCESSION NUMBER: 160210  
DATE OF OCCURRENCE: 9010  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SEZ  
FACILITY STATE: AZ  
FACILITY TYPE: ARPT;  
FACILITY IDENTIFIER: SEZ;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; UNCTRLED ARPT  
TRAFFIC PATTERN DEVIATION; OTHER; NON ADHERENCE LEGAL RQMT/FAR;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: THE INCIDENT OCCURRED AT SEDONA ARPT. TFC WAS  
LNDG UPHILL ON RWY 03 AND DEPARTING DOWNHILL ON RWY 21. I WAS  
DEPARTING SEDONA. I TAXIED FROM PARKING TO RWY 21, COMPLETED MY  
PREFLT AND WAS READY TO DEPART. I HAD BEEN MONITORING THE CTAF  
AND DIDN'T HEAR ANY ACFT IN THE PATTERN. I ANNOUNCED MY INTENTION  
TO DEPART SEZ ON RWY 21 AND TAXIED ONTO THE RWY. I DIDN'T SEE ANY  
TFC APCHING. AS I TAXIED ONTO THE RWY, I HEARD AN ACFT ANNOUNCE  
IT WAS TURNING BASE FOR RWY 03. INSTEAD OF HOLDING AT THE END OF  
THE RWY, I BEGAN MY TKOF ROLL, THINKING I WOULD BE OFF AND CLB  
OUT OVER THE PATH OF THE LNDG ACFT. THE OTHER ACFT HEARD/SAW ME  
AND EXECUTED A GO-AROUND, TURNING R OUT OF THE DEP PATH. BECAUSE  
OF THE OTHER PLT'S EVASIVE ACTION, OUR 2 ACFT REMAINED AT SAFE  
DISTANCES. BUT I SHOULD HAVE YIELDED THE RIGHT-OF-WAY TO THE LNDG  
ACFT. (LNDG ACFT WAS A HIGH FIXED WING GA ACFT). CONTRIBUTING  
FACTORS. I HAD JUST COMPLETED MY AFR AFTER NOT FLYING AT ALL FOR  
2 YRS; MY HEAD WORK WAS RUSTY. I WAS TIRED, HAD NOT SLEPT WELL  
THE NIGHT BEFORE. THE SITUATION OF TFC LNDG AND DEPARTING IN OPP  
DIRECTIONS IS UNUSUAL. ONCE I TOOK THE RWY, I FELT COMMITTED TO  
TKOF, A BAD JUDGEMENT. WHAT WOULD HAVE PREVENTED THE CONFLICT. I  
SHOULD HAVE ASKED UNICOM FOR A TFC ADVISORY BEFORE TAXIING ONTO  
THE RWY, AND LOOKED MORE CAREFULLY FOR TFC IN THE PATTERN. I ALSO  
COULD HAVE WAITED A FEW MOMENTS AFTER ANNOUNCING MY INTENTION TO  
DEPART ON THE CTAF TO SEE IF ANY OTHER ACFT ANNOUNCED THEIR  
POSITIONS IN THE PATTERN. I COULD HAVE HELD AT THE END OF THE RWY  
FOR THE ARRIVING TFC TO LAND AND CLR THE RWY. ANOTHER PREVENTION,  
GIVEN THE UNUSUAL TFC PATTERN, WOULD HAVE BEEN TO ANTICIPATE AND  
DECIDE AHEAD OF TIME WHAT SAFE/UNSAFE CONDITIONS FOR TAKING OFF  
(VIS-A-VIS OTHER LCL TFC POSITIONS). FINALLY, NOT FLYING WHEN  
TIRED, IT DID SEEM TO AFFECT MY JUDGEMENT.

SYNOPSIS: CLOSE PROX GA SMA ON TKOF FROM RWY 21 AND GA SMA  
IN LNDG PATTERN FOR RWY 03.

REFERENCE FACILITY ID:SEZ  
FACILITY STATE: AZ  
DISTANCE & BEARING FROM REF.: , ,SW  
AGL ALTITUDE: 0,500

ACCESSION NUMBER: 160654  
 DATE OF OCCURRENCE: 9010  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC,TRNEE; FLC,ISTR; FLC,PLT; TWR,LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:BVI  
 FACILITY STATE: PA  
 FACILITY TYPE: TWR;  
 FACILITY IDENTIFIER: BVI;  
 AIRCRAFT TYPE: SMA; SMA;  
 ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/FAR;  
 ANOMALY DETECTOR: ATC/CTLR;  
 ANOMALY RESOLUTION: NOT RESOLVED/ANOMALY ACCEPTED;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: ARPT WAS OPERATING OFF OF RWY 10 IN A RIGHT-HAND  
 TFC PATTERN. THERE WERE APPROX 8 OTHER ACFT IN THE CTL ZONE AREA.  
 WHILE ON DOWNWIND, MY INSTR AND I BEGAN TO HEAR A RATHER URGENT  
 AND PANICKY-SOUNDING CTLR INSTRUCTING AN SMA Y TO "LOOK FOR THE  
 SMA X OFF OF YOUR RIGHT WING." THE CTLR REPEATED THIS OVER AND  
 OVER, EACH TIME SOUNDING MORE PANICKED. THE SMA Y EACH TIME  
 REPLIED THAT HE DID NOT SEE THE SMA X. SUDDENLY, OUT OF THE  
 CORNER OF MY EYE, I SAW THE SMA Y APPROX 50' VERT AND 100' HORIZ  
 TO THE RIGHT OF MY ACFT. I WAS THE SMA X THAT THE CTLR WAS  
 REFERRING TO! THE TWR AT THIS ARPT IS A NON-FEDERAL FAC THAT IS  
 USED PRIMARILY AS A TRNG FAC FOR A LCL COLLEGE. I AM UNCERTAIN  
 IF THE CTLR ON DUTY WAS A STUDENT; HOWEVER, SHE SOUNDED AS IF SHE  
 WAS HAVING TROUBLE HANDLING THIS PRE-EVENING CRUNCH OF TFC  
 BECAUSE JUST BEFORE THE INCIDENT, SHE ANNOUNCED THAT ALL TFC MUST  
 BE FULL STOP AND THAT ALL TOUCH AND GO'S WERE CANCELLED.  
 ADDITIONALLY, HER VOICE SOUNDED VERY FLUSTERED. THE PLT OF THE  
 SMA Y WAS ALSO A STUDENT. I WAS UNABLE TO SEE THE SMA Y COMING  
 TOWARD ME BECAUSE I WAS IN A SLIGHT NOSE HIGH ATTITUDE, CLBING TO  
 PATTERN ALT. THE CTLR KNEW THAT I WAS HEADED TOWARD THIS "LOST"  
 SMA Y. IT HAPPENED AT MID-FIELD, RIGHT IN FRONT OF HER! WHY  
 WASN'T I MADE AWARE OF THE SITUATION SO I COULD'VE TAKEN EVASIVE  
 ACTION IF NECESSARY? INSTEAD, THE CTLR JUST RAISED HER VOICE AND  
 EXPECTED THE SMA Y TO SEE THE SMA X. UNFORTUNATELY, THERE WERE AT  
 LEAST 4 OTHER SMA X'S IN THE PATTERN. IT COULD'VE BEEN ANY ONE OF  
 THEM. SHE KNEW MY CALL SIGN BECAUSE I WAS #4 TO LAND, I FEEL THAT  
 SHE SHOULD'VE TURNED ME LEFT, OUT OF THE PATTERN AS A CORRECTIVE  
 ACTION INSTEAD OF JUST RAISING HER VOICE. SITUATION AWARENESS  
 WOULD HAVE BENEFITTED ALL INVOLVED IN THIS INCIDENT!  
 SYNOPSIS: CLOSE PROX 2 GA SMA IN TRAFFIC AT BVI.  
 REFERENCE FACILITY ID:BVI  
 FACILITY STATE: PA  
 DISTANCE & BEARING FROM REF.: 1,,SO  
 MSL ALTITUDE: 1900,2000

ACCESSION NUMBER: 161078  
DATE OF OCCURRENCE: 9010  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:HLF  
FACILITY STATE: FO  
FACILITY TYPE: ARTCC;  
FACILITY IDENTIFIER: OEJD;  
AIRCRAFT TYPE: WDB; ;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL  
SEPARATION;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT; NOT  
RESOLVED/INSUFFICIENT TIME;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: AS MY ACFT PASSED OVER HLF VOR AT FL310 AND MADE  
POS RPT, WE HEARD ANOTHER ACFT RPT THE SAME POS AT THE SAM FLT  
LEVEL. WE WERE WBND ON 2726 AND OTHER ACFT WAS ON A DIRECT LEG  
APCHING 45 DEGS FROM LEFT. WE NOTICED OTHER ACFT AT OUR 8 O'CLOCK  
POS, LESS THAN 1/4 MI. NO EVASIVE ACTION NECESSARY OR TAKEN.  
SYNOPSIS: LESS THAN STANDARD SEPARATION AT FL310 IN  
FOREIGN AIRSPACE.  
REFERENCE FACILITY ID:HLF  
FACILITY STATE: FO  
MSL ALTITUDE: 31000,31000

ACCESSION NUMBER: 169841  
DATE OF OCCURRENCE: 9102  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: IMC  
REFERENCE FACILITY ID: LUK  
FACILITY STATE: OH  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: LUK; LUK;  
AIRCRAFT TYPE: SMA;  
ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/WX; NON ADHERENCE LEGAL  
RQMT/CLNC; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC; NON ADHERENCE  
LEGAL RQMT/FAR;

ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/ANOMALY ACCEPTED;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: ON MY FIRST POST-INS CHKRIDE FLT IN IMC, I WAS RETURNING TO LUK FROM MWO (APPROX 1/2 HR FLT). I HAD PICKED UP LIGHT ICE ON THE WAY OUT AND HAD MADE A PIREP. I PICKED UP SOME LIGHT TO MODERATE MIXED ICE ENRTE AT 3000' MSL. AN ACFT AHEAD OF ME ON THE APCH RPTED HEAVY ICE BUILDUP FROM 2700' ON DOWN TO 1700'. AS I WAS VECTORED FOR THE APCH, THE ICE STARTED TO BUILD VERY RAPIDLY. BY THE TIME I WAS ESTABLISHED ON THE APCH (OUTSIDE OF THE BEACON), I WAS AT FULL PWR AND BARELY MAINTAINING ALT AT LESS THAN 80 KIAS. I ATTEMPTED TO REMAIN ABOVE THE G/S, BUT COULD NOT. I ADVISED LUK TWR THAT I WOULD DSND TO 1700' (100' ABOVE THE MDA FOR THE LOC APCH), WHICH IS WHERE THE PREVIOUS ACFT HAD RPTED ICE BUILDUP CEASING. HOWEVER I CONTINUED TO BUILD ICE. I ALSO HAD TO KEEP CARB HEAT FULL ON AND PLAY WITH RPM'S TO LOOSEN PROP ICE. I HAD ADVISED TWR AND APCH SEVERAL TIMES OF MY SITUATION (BUT OF COURSE THEY COULD NOT HELP). APPROX 3 MI INSIDE MDE I DOUBLE-CHKED THE BASES AND MADE MY DECISION TO DSND TO 1400' (200' BELOW THE MDA). I MADE THIS CHOICE BECAUSE, WITH THE WAY THE ICE WAS BUILDING, I WAS GOING DOWN ANYWAY, AND BECAUSE OF THE FACT THAT I AM VERY FAMILIAR WITH THE AREA. AS I BROKE OUT AT 1400' TWR ASKED MY ALT. I RESPONDED, "1400' OUT OF THE CLOUDS." I HAD VIS CONTACT WITH THE ARPT AND NEW EXACTLY MY POS (I RPTED A LCL SHOPPING CENTER TO MY RIGHT). BY THE TIME I REACHED THE ARPT, SOME ICE HAD SUBLIMATED, BUT VERY LITTLE. IN A FULL STALL LNDG I WAS 3-4 KIAS SLOWER THAN I HAVE BEEN ON THE APCH. I WOULD NOT HAVE MADE THE DECISION TO DSND BELOW THE MDA IF I HAD NOT BEEN VERY FAMILIAR WITH THE ARPT. WHEN I HAD RECEIVED MY BRIEFING FOR THIS FLT, THERE WERE NO PLT RPTS OF ICE IN THE AREA. YET FROM DISCUSSING THE INCIDENT WITH CTLRS AND GND CREW, NUMEROUS ACFT HAD COME IN WITH ICE. 2 THINGS WOULD HAVE MADE ME TAKE THE BUS HOME: GREATER STRESS ON THE HAZARDS OF ICING DURING INS FLYING, AND PIREPS IN THE AREA.

SYNOPSIS: GA SMA ENCOUNTERED ICE ON APCH TO LUK AND  
DESCENDED BELOW MDA TO GET CLEAR OF CLOUDS.

REFERENCE FACILITY ID: LUK  
FACILITY STATE: OH  
DISTANCE & BEARING FROM REF.: , , NE  
MSL ALTITUDE: 1400, 3000

ACCESSION NUMBER: 174511  
DATE OF OCCURRENCE: 9104  
REPORTED BY: FLC; FLC; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:MDW  
FACILITY STATE: IL  
FACILITY TYPE: TWR; ARPT;  
FACILITY IDENTIFIER: MDW; MDW;  
AIRCRAFT TYPE: MLG; SMT;  
ANOMALY DESCRIPTIONS: ACFT EQUIPMENT PROBLEM/LESS SEVERE; OTHER; RWY  
TRANSGRESS/OTHER; NON ADHERENCE LEGAL RQMT/CLNC; NON ADHERENCE  
LEGAL RQMT/FAR;  
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
ANOMALY RESOLUTION: FLC ABORTED TKOF;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE:

OUR FLT, MLG X, WAS CLRED FOR TKOF RWY 13C. A  
LIGHT TWIN, SMT Y, HAD JUST LANDED 1 MIN BEFORE ON RWY 13L. PWR  
WAS ADVANCED AND TKOF ROLL COMMENCED WITH CAPT SETTING TKOF PWR.  
AT APPROX 100 KTS, I NOTICED AN ACFT AT DEP END OF RWY AT A  
FAIRLY GOOD TAXI SPD, APCHING OUR RWY. AT THE SAME TIME I HEARD  
THE TWR CTLR MAKING SEVERAL ATTEMPTS TO RAISE TXWY SMT Y ON FREQ  
TO NO AVAIL. I TOLD CAPT THAT I THOUGHT AN ACFT WAS GOING TO  
CROSS OUR RWY DOWNFIELD. THE CAPT LOOKED OUT AND ALSO OBSERVED  
INTRUSION AHEAD. CAPT MADE DECISION TO ABORT TKOF AT APPROX 115  
KTS (11 KTS BELOW V1). SMT Y NEVER DID STOP AND TWR WAS FINALLY  
ABLE TO RAISE HIM ONCE HE CROSSED OUR RWY. OUR ACFT CAME TO A  
STOP ABOUT 2000' PRIOR TO WHERE SMT Y CROSSED IN FRONT OF US. IF  
TKOF WOULD HAVE BEEN CONTINUED AT OUR FAIRLY LIGHT WT, AND WITH  
SLIGHTLY MORE AGGRESSIVE ROTATION THAN NORMAL, WE WOULD HAVE  
CLRED SMT Y BY 100-200'. WORKLOAD OF LCL CTLS AT THE TIME WAS  
FAIRLY BUSY. WX WAS GOOD IF MVFR OR IFR. OUR NOT BEING AWARE OF A  
POSSIBLE CONFLICT SITUATION COULD HAVE HAD MUCH MORE SERIOUS  
CONSEQUENCES. SUPPLEMENTAL INFO FROM ACN 174775: TWR CTLR MADE  
SEVERAL ATTEMPTS AT REQUESTING THE ACFT TO HOLD SHORT OF 13C WITH  
NO RESPONSE. THE LIGHT TWIN DID CROSS 13C. RED LIGHTING ALONG THE  
HOLD LIENS ON TXWYS MAY HELP AVOID SOME OF THESE PROBS.

SYNOPSIS: ACR MLG ABORTS TKOF ABOVE 100 KTS ON RWY 13C AT  
MDW FOR GA SMT Y CROSSING ACTIVE RWY WITHOUT CLRNC.  
REFERENCE FACILITY ID:MDW  
FACILITY STATE: IL  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 177457  
DATE OF OCCURRENCE: 9105  
REPORTED BY: FLC; ; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PIC.CAPT; FLC, FO;  
TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SFO  
FACILITY STATE: CA  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: SFO; SFO;  
AIRCRAFT TYPE: MLG; MLG;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; TRACK OR HDG DEVIATION; NON  
ADHERENCE LEGAL RQMT/CLNC; NON ADHERENCE LEGAL RQMT/PUBLISHED  
PROC;

ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: IN 5/91, WE EXPERIENCED A NEAR MISS BTWN 300 AND  
200' AGL WHILE IN THE PROCESS OF LNDG AT SFO. WE WERE ACR X FLT  
FROM PIT, AN MLG X, AND THE OTHER ACFT WAS ACR Y FLT FROM LAX,  
ALSO AN MLG Y. WE WERE CLRED FOR THE QUIET BRIDGE APCH. WE  
CLEARLY HAD THE ARPT IN SIGHT. WE WERE ASSIGNED A SPD OF 170 KTS,  
WHICH WAS REDUCED TO 160 KTS JUST PRIOR TO BRIDGE. APCH POINTED  
OUT OUR TFC TO FOLLOW WAS A HEAVY, AND OUR LNDG "PARTNER" AN MLG  
Y FOR THE LEFT. APCH SAID THAT OUR SPD WAS TO PAIR US UP WITH  
PARALLEL TFC. I OFFSET SLIGHTLY TO THE E OF THE LOC TO AVOID THE  
HVT WAKE TURB, AND ALSO TO GIVE US PLENTY OF CLRNC WITH THE  
PARALLEL TFC. WE WERE ABEAM THE OTHER INSIDE OF BRIJJ. THE WIND  
WAS 280/23 AT 4000'. AT ABOUT 300', WE WERE STILL SLIGHTLY  
DISPLACED TO THE RIGHT OF THE LOC, FEELING A LITTLE CROWDED BY  
THE MLG Y JET, BUT STILL IN A COMFORTABLE PLACE TO LAND. I SAID  
TO THE CAPT, "HE'S GOING ABOVE G/S." HE THEN MADE A MOVE TO LINE  
UP WITH THE 28R. I TURNED MORE TO THE RIGHT TO AVOID HIM. THE  
CAPT THEN SAID ON THE RADIO, "TWR, CONFIRM THE LNDG RWY FOR ACR  
Y." THE RESPONSE WAS, "FOR 28L." AT ABOUT 200' THE ACR Y ACFT  
ADDED PWR, PULLED UP, AND BANKED SHARPLY TO THE LEFT. HE MANAGED  
TO LAND W/O INCIDENT ON THE LEFT. WE WERE ABLE TO MAINTAIN G/S  
THE WHOLE TIME, BUT WE WERE DISPLACED TO THE RIGHT OF THE LOC.  
THE CONTRIBUTING FACTORS WERE: 1) THE ACR Y PLTS SOMEHOW MISSED  
THEIR CLRNC TO THE LEFT RWY WAY BACK AT MENLO. 2) SINCE THE PLTS  
WERE BASED IN CHICAGO, PERHAPS THEY WEREN'T USED TO THE NORMAL  
OCCURRENCE OF PARALLEL TFC ON THE TIPTOE/QUIET BRIDGE APCHS. THE  
LOC FOR 28L (108.5) WAS NOTAMED OUT, SO HE MAY HAVE TALKED  
HIMSELF INTO A 28R LNDG BY TUNING IN 111.7--INITIALLY JUST FOR  
G/S, BUT THEN TRACKING THE LOC.

SYNOPSIS: CLOSE PROX 2 ACR MG ACFT ON VISUAL BRIGG APCH TO  
SFO AT NIGHT.

REFERENCE FACILITY ID:SFO  
FACILITY STATE: CA  
DISTANCE & BEARING FROM REF.: 1,281  
AGL ALTITUDE: 300,300

ACCESSION NUMBER: 182661  
DATE OF OCCURRENCE: 9107  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; MISC,PAX;  
FLIGHT CONDITIONS: IMC  
REFERENCE FACILITY ID:DBN  
FACILITY STATE: GA  
FACILITY TYPE: ARTCC;  
FACILITY IDENTIFIER: ZTL;  
AIRCRAFT TYPE: MLG;  
ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/WX;  
ANOMALY DETECTOR: OTHER;  
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;  
ANOMALY CONSEQUENCES: INJURY;  
NARRATIVE: WE WERE DSNDING FROM FL370 TO FL330 AND

DEVIATING TO THE W TO AVOID A COUPLE OF TSTM CELLS. THE RIDE HAD BEEN SMOOTH. WE WERE IMC IN A CIRRUS DECK AND THERE WAS NO WX ON OUR RADAR EXCEPT FOR THE CELLS WE WERE GOING AROUND. WE WERE AVOIDING THEM BY ABOUT 25-30 MI. OTHER ACFT HAD ALSO DEVIATED W WITH NO RPTS OF TURB. THE VISIBILITY WAS POOR, BUT WE SUDDENLY SPOTTED A SMALL CUMULUS CLOUD ON OUR NOSE. WE TRIED TO TURN TO AVOID IT BUT WERE UNABLE. THERE HAD BEEN NO INDICATION OF THIS WX ON OUR RADAR SCOPE. THE CAPT HAD TURNED ON THE SEAT BELT SIGN PRIOR TO THIS. A PAX WAS IN THE AFT LAVATORY AT THIS TIME. WE ENCOUNTERED MODERATE TURB FOR ABOUT 10 SECONDS. THE PAX APPARENTLY SUFFERED A BROKEN LEG AND WAS MET BY PARAMEDICS AND COMPANY AGENTS IN ATLANTA.

SYNOPSIS: ACR MLG HIT THE TOP OF TSTM BUILD UP. PAX IN AFT LAVATORY BROKE A LEG.

REFERENCE FACILITY ID:DBN  
FACILITY STATE: GA  
DISTANCE & BEARING FROM REF.: 25,180  
MSL ALTITUDE: 34500,34500

ACCESSION NUMBER: 184839  
DATE OF OCCURRENCE: 9107  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID: OSH  
FACILITY STATE: WI  
FACILITY TYPE: TWR; TRACON;  
FACILITY IDENTIFIER: OSH; OSH;  
AIRCRAFT TYPE: SMA;  
ANOMALY DESCRIPTIONS: ACFT EQUIPMENT PROBLEM/LESS SEVERE; OTHER;  
ANOMALY DETECTOR: COCKPIT;  
ANOMALY RESOLUTION: NOT RESOLVED/OTHER;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;

NARRATIVE: AFTER BEING HANDED OFF FROM CHICAGO CENTER TO OSHKOSH APCH, APCH SAID OUR TRANSMISSION WAS GARBLED AND ASKED US TO CHANGE FREQS. IN GOING FROM ONE RADIO TO THE OTHER THE RADIO SELECTOR KNOB ON THE AUDIO PANEL BROKE IN THE #3 POS, WHERE NO RADIO EXISTS. WE COULD HEAR APCH AND TWR OK BUT WE COULD NOT XMIT. DURING THE CONVENTION (JUST PRIOR) OSHKOSH AIRSPACE IS PANDEMONIUM - I ELECTED TO FOLLOW IFR RADIO OUT PROCS AND LAND VFR WITHOUT A LNDG CLRNC. NO CONFLICT OCCURRED. I COULD HEAR TWR ADVISING OTHER ACFT OF OUR NORDO SITUATION (BECAUSE WE WERE NOT ANSWERING THEM) AND THAT THEY HOPED WE WOULD 'LAND SHORT' SO OTHERS COULD LAND LONG. AT THAT TIME I COULD NOT TELL IF TWR EVEN KNEW WE WERE IFR TFC. AFTER LNDG (VERY SHORT) BUT WELL ON THE APPROPRIATE SECTION OF THE RWY, WE IMMEDIATELY EXITED THE RWY ONTO THE GRASS AND I CALLED (AFTER TYING DOWN) GREEN BAY FSS TO CLOSE THE FLT PLAN (SINCE I DIDN'T THINK TWR WOULD DO IT) AND ASKED GREEN BAY TO CALL OSHKOSH TWR AND EXPLAIN WHAT HAPPENED - HE SAID HE WOULD. TENSE MOMENTS!

SYNOPSIS: SMA ON IFR FLT PLAN TO OSH HAS RADIO FAILURE.  
CAN RECEIVE BUT NOT XMIT. FOLLOWS IFR RADIO OUT PROCS.

REFERENCE FACILITY ID: OSH  
FACILITY STATE: WI  
DISTANCE & BEARING FROM REF.: 1,,E  
AGL ALTITUDE: 0,800

ACCESSION NUMBER: 185329  
DATE OF OCCURRENCE: 9108  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; TWR,LC; FLC,PLT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:IPT  
FACILITY STATE: PA  
FACILITY TYPE: TWR;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;  
ANOMALY DETECTOR: COCKPIT;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;

NARRATIVE: AN SMA A FLOATPLANE, WAS INBOUND TO THE IPT VOR AT 3400 MSL, COURSE 010 MAGNETIC. SMA A CALLED THE TWR AT IPT 8.1 DME FROM THE VOR, INDICATING THE INTENTION TO CONTINUE INBOUND TO THE VOR AND DEPART NE TO N27. THE IPT TWR RESPONDED IN THE AFFIRMATIVE, REQUESTING A RPT WHEN N OF THE RWY CENTERLINE IF VISIBLE. IMMEDIATELY THEREAFTER, THE IPT TWR CLRED AN SMA B TO FLY A LOC APCH INTO IPT. THE SMA B RPTED 4000 MSL, DSNDING. UPON HEARING THE SMA B RPTING ITS POS AT 'PICTURE ROCKS', A TOWN MARKED ON THE VFR SECTIONAL, SMA A QUERIED THE SMA B DIRECTLY FOR ALT. THE SMA B REPLIED 3700 DSNDING. SMA A IMMEDIATELY BEGAN CIRCLING TO HOLD A POS S OF THE LOC UNTIL THE SMA B HAD PASSED, NOTIFYING THE TWR OF 'EVASIVE ACTION'. AFTER TURNING APPROX 110 DEG TO THE R, SMA A OBSERVED THE SMA B PASSING ABOUT 100 FT BELOW AND 300 FT N. SMA A THEN RESUMED ITS PROGRESS TOWARD THE VOR AND WAS NOTIFIED BY THE IPT TWR THAT THERE WAS NO TFC TO RPT. THE MAIN CONTRIBUTING FACTOR WAS THE ACTION OF THE IPT TWR CLRING 2 ACFT WITHIN ITS CTL ONTO A COLLISION COURSE. SMA A WAS CLRED TO CROSS THE LOC AT 3400 FT AT THE SAME TIME THE SMA B WAS CLRED TO CONDUCT A LOC APCH STARTING AT 4000 FT. THE RPTR FEELS THAT THE SMA B LOCATION WAS AS MUCH AS A MI S OF THE LOC APCH, NEGATING THE EFFECTIVENESS OF HIS HOLDING ACTION. THE DISCUSSION OF THE 'PICTURE ROCKS' INBOUND LOC WAYPOINT, WHICH WAS ON THE VFR SECTIONAL, ALERTED SMA A TO THE IMMINENT POTENTIAL FOR A COLLISION. EVASIVE ACTION BY SMA A PREVENTED A VERY NEAR MISS OR A POSSIBLE COLLISION. THE HUMAN PERFORMANCE OF THE IPT ATA CTLR FAILED TO ENHANCE THE ACFT SEPARATION WITHIN THE BOUNDS OF THE ATA. THE RPTR FEELS THAT THE TWR CTLR AT IPT DID NOT HAVE A PICTURE OF THE TFC WITHIN THE ATA. THE CTLR'S JUDGEMENT AND SUBSEQUENT INACTION, CREATED A VERY HAZARDOUS CIRCUMSTANCE. I FEEL THAT THE CTLR SHOULD HAVE DIRECTED SOME ACTION TO CREATE POSITIVE VERT OR HORIZ SEPARATION RATHER THAN SIMPLY LEAVING IT UP TO THE AIRCREWS INVOLVED TO PROVIDE SEPARATION VIA SEE-AND-AVOID. I RECOGNIZE THAT SEE-AND-AVOID IS A CONTINUING AIRCREW RESPONSIBILITY, BUT WHEN UNDER POSITIVE CTL IN AN ATA, THE CTLR IS EXPECTED TO HELP BY POSITIVE ACTIONS ENHANCING SEPARATION.

SYNOPSIS: SMA CLRED TO VOR AS SECOND ACFT CLRED FOR ILS APCH. NMAC.

REFERENCE FACILITY ID:IPT  
FACILITY STATE: PA  
DISTANCE & BEARING FROM REF.: 8,,SO  
MSL ALTITUDE: 3300,3400

ACCESSION NUMBER: 188555  
DATE OF OCCURRENCE: 9109  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PIC.CAPT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:PDX  
FACILITY STATE: OR  
FACILITY TYPE: TWR; ARPT;  
FACILITY IDENTIFIER: PDX; PDX;  
AIRCRAFT TYPE: LRG; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; OTHER; NON  
ADHERENCE LEGAL RQMT/PUBLISHED PROC;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: I WAS WAITING FOR IFR DEP. WAS TOLD TO TAXI INTO POS AND HOLD RWY 28R. RIGHT AFTER THIS ACR X CHKED ON AND RPTED THAT HE WAS ON THE VISUAL FOR THE R. AFTER MORE THAN 1 MIN OF WAITING I TURNED MY ACFT (SMA Y) APPROX 40 DEG TO THE L. THIS ALLOWED ME BOTH TO SEE THE ARRIVING ACFT AND ALSO POS THE ACFT TOWARDS THE TURNOFF. AFTER I DID THIS I NOTICED ACR X WAS GETTING VERY CLOSE. I CONTACTED TWR, SAYING THAT I WAS STILL IN POS AND HOLD ON THE R. TWR CAME BACK WITH A VERY REAL SENSE OF URGENCY AND TOLD ME TO TURN L AND EXIT THE RWY IMMEDIATELY. FORTUNATELY I WAS ALREADY FACING TOWARDS THAT DIRECTION AND QUICKLY GOT OFF THE RWY. I ESTIMATE THAT LESS THAN 1 1/2 SECONDS PASSED BTWN ME XING THE HOLD LINE EXITING THE RWY AND ACR X XING THE THRESHOLD. SHADES OF LAX CROSSED MY MIND. AFTER THIS I WAS AGAIN TOLD TO TAXI INTO POS AND HOLD, AND DEP WAS UNEVENTFUL. I FEEL THAT POS AND HOLD GAINS CTLRS VERY LITTLE WITH SMALL PLANES AND THAT IT SHOULD NEVER BE USED UNLESS DEP IS ENSURED IN A VERY TIMELY FASHION (LESS THAN 30 SECS). I HATE TO THINK WHAT WOULD HAVE HAPPENED IF I HAD NOT BEEN LISTENING TO THE RADIO AND NOTICED THE OTHER PLANE COMING IN. I MIGHT ADD THAT THE TWR FREQ WAS NOT VERY BUSY AT THE TIME. I THINK THE CTLR JUST FORGOT ABOUT ME.

SYNOPSIS: SMA TOLD TO TAXI INTO POS AND HOLD. CTLR CLRED AN ACR TO LAND ON THE RWY AND FORGOT ABOUT THE SMA. SMA ADVISED THE TWR BEFORE AN INCIDENT OCCURRED.

REFERENCE FACILITY ID:PDX  
FACILITY STATE: OR  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 190783  
 DATE OF OCCURRENCE: 9110  
 REPORTED BY: FLC; ; ; ;  
 PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; TRACON,DC; FLC, PIC.CAPT;  
 FLIGHT CONDITIONS: IMC  
 REFERENCE FACILITY ID:MCI  
 FACILITY STATE: MO  
 FACILITY TYPE: TRACON; ARPT;  
 FACILITY IDENTIFIER: MCI; MCI;  
 AIRCRAFT TYPE: MLG; ;  
 ANOMALY DESCRIPTIONS: LESS THAN LEGAL SEPARATION; OTHER; ALT  
 DEV/OVERSHOOT ON CLB OR DES; NON ADHERENCE LEGAL RQMT/PUBLISHED  
 PROC;  
 ANOMALY DETECTOR: COCKPIT/FLC; COCKPIT/EQUIPMENT;  
 ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: DEPARTED RW01. SWITCHED AS ASSIGNED TO WORK DEP  
 ON 126.6, ASSIGNED HDG AND CLB TO 7000 FT, ALSO, GIVEN TFC AT  
 7000 OPPOSITE DIRECTION XYZ AIRLINER. AT ABOUT THE SAME TIME THE  
 CTLR CALLED THE TFC AT 2 O'CLOCK DSNDING TO 7000. WE SPOTTED  
 SUSPECT ACFT ON TCASII AT 10 O'CLOCK. XYZ TFC WAS ALSO ISSUED 2  
 O'CLOCK TFC (SUPPOSEDLY OUR ACFT) CLBING TO 6000. WELL, WE WOULD  
 HAVE BEEN AT XYZ'S 10 O'CLOCK AS WELL AND HAD JUST BEEN ASSIGNED  
 7000. A TFC ALERT WAS RECEIVED, THE CTLR SAID 'MLG MAINTAIN 6000'  
 AS WE VERBALLY QUESTIONED OUR ASSIGNED ALT TO 6000, AS WOULD HAVE  
 BEEN EXPECTED IF THE CTLR KNEW WHERE WE WERE. WHEN THE CTLR  
 REALIZED THERE MAY BE AN ERROR/CONFLICT, HE ISSUED US A L TURN,  
 WHICH WOULD HAVE AGGRAVATED THE SITUATION, AS TARGET ACFT WAS ON  
 TCASII TA AT 10 O'CLOCK AND CLOSING. CAPT RAISED FLT SPOILERS,  
 TURNED ABOUT 30 DEG R, AND WENT DOWN TO 6000. NO RA WAS PRESENT,  
 BUT THANK GOD WE HAD TCASII, BECAUSE WITHOUT IT WE WOULD HAVE  
 TURNED DIRECTLY INTO THE PATH OF THAT INBOUND, OPPOSITE DIRECTION  
 AIRLINER.  
 SYNOPSIS: ACR ISSUED CLB TO 7000 FT WHEN CHANGED TO DEP  
 FREQ. TAKES EVASIVE ACTION WHEN TCASII TA INDICATES TFC AND CTLR  
 CALLS TFC AT SAME ALT.  
 REFERENCE FACILITY ID:MCI  
 FACILITY STATE: MO  
 DISTANCE & BEARING FROM REF.: 10,,N  
 MSL ALTITUDE: 6000,7000

ACCESSION NUMBER: 193844  
DATE OF OCCURRENCE: 9111  
REPORTED BY: FLC; ; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PLT; MISC,FSS;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:BTM  
FACILITY STATE: MT  
FACILITY TYPE: ARPT; FSS;  
FACILITY IDENTIFIER: BTM; BTM;  
AIRCRAFT TYPE: LTT; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; UNCTRLED ARPT TRAFFIC  
PATTERN DEVIATION; NON ADHERENCE LEGAL RQMT/FAR;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: WE WERE LNDG AT BTM. WE WERE ADVISED THAT THE  
ACTIVE RWY WAS 33 BUT THERE WAS AN ACFT DOING TOUCH AND GOES ON  
15 WHO WAS COMMUNICATING BUT COULD NOT HEAR. HE ANNOUNCED HE WAS  
DOWNWIND FOR 15 WHEN WE WERE ON FINAL FOR 33 THAT WAS THE LAST WE  
HEARD FROM HIM. WE DID NOT SEE HIM UNTIL WE WERE BOTH ON THE GND  
HDG AT EACH OTHER. WE BRAKED HARD AND WERE STOPPED WITHIN 1500 FT  
OF HIM.  
SYNOPSIS: GND CONFLICT BTWN COMMUTER LTT AND A GA SMA LNDG  
OPPOSITE DIRECTION.  
REFERENCE FACILITY ID:BTM  
FACILITY STATE: MT  
AGL ALTITUDE: 0,0

**ADVISORY PLI ELEMENTS: Correct Transmission, Incorrect Action**

ACCESSION NUMBER: 129866  
DATE OF OCCURRENCE: 8911  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; MISC,GNDCREW;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID: BWI  
FACILITY STATE: MD  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: BWI; BWI;  
AIRCRAFT TYPE: MLG;  
ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/OTHER; ACFT EQUIPMENT  
PROBLEM/CRITICAL;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;  
ANOMALY CONSEQUENCES: ACFT DAMAGED;

NARRATIVE: RIGHT AFTER LIFTOFF ON RWY 28, I ENCOUNTERED A LARGE FLOCK OF SEA GULLS. I HEARD ONE STRIKE THE ACFT AND CONTINUED THE TKOF, MONITORING THE ENG INSTRUMENTS CLOSELY. I HAD THE F/O TELL THE TWR ABOUT THE LARGE FLOCK OF BIRDS. AFTER SWITCHING TO DEP CTL, WE CLBED EXPEDITIOUSLY THROUGH HIS AIRSPACE, WAS HANDED OFF TO ZDC AND CLRED TO FL250. ONLY THEN WAS CLB PWR REDUCED, AT WHICH TIME THE #2 ENG VIBRATION INDICATOR WENT FROM LESS THAN 1 TO 3-4. I ELECTED TO STAY AT FL250 AND CALLED COMPANY MAINT CTL. WE AGREED I SHOULD DIVERT, SO I LANDED AT GSO W/O FURTHER INCIDENT. POSTFLT INSPECTION REVEALED NUMEROUS BIRD STRIKES, INCLUDING SEVERAL #2 ENG FIRST STAGE FAN BLADES DAMAGED AND A LARGE DENT IN THE #2 ENG COWL. THIS INCIDENT COULD HAVE HAD DISASTROUS CONSEQUENCES. THE BIRDS MUST HAVE FLOWN JUST AT ROTATION, AND ONLY BY ROTATING HIGHER THAN NORMAL WAS I ABLE TO MISS THE MAJORITY OF THEM (I THOUGHT I HAD HIT ONLY 1). A PLT WHO HAD JUST LANDED RPTD THE FLOCK OF BIRDS AS I WAS IN THE TKOF ROLL, BUT EITHER HE DIDN'T SPECIFY THEIR EXACT LOCATION OR I DIDN'T HEAR IT. MORE TIMELY AND SPECIFIC INFO MIGHT HAVE LED TO DIFFERENT ACTIONS ON MY PART.

SYNOPSIS: ACR MLG BIRD STRIKE ON TKOF FROM BWI. NOT INDICATED ENGINE PROBLEM UNTIL POWER REDUCED TO CLIMB, THEN ENGINE VIBRATION CAUSED FLT CREW TO CALL COMPANY MAINTENANCE AND SUBSEQUENTLY DIVERT TO ALTERNATE.

REFERENCE FACILITY ID: BWI  
FACILITY STATE: MD  
AGL ALTITUDE: 50,100

ACCESSION NUMBER: 160210  
DATE OF OCCURRENCE: 9010  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SEZ  
FACILITY STATE: AZ  
FACILITY TYPE: ARPT;  
FACILITY IDENTIFIER: SEZ;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; UNCTRLED ARPT  
TRAFFIC PATTERN DEVIATION; OTHER; NON ADHERENCE LEGAL RQMT/FAR;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: THE INCIDENT OCCURRED AT SEDONA ARPT. TFC WAS LNDG UPHILL ON RWY 03 AND DEPARTING DOWNHILL ON RWY 21. I WAS DEPARTING SEDONA. I TAXIED FROM PARKING TO RWY 21, COMPLETED MY PREFLT AND WAS READY TO DEPART. I HAD BEEN MONITORING THE CTAF AND DIDN'T HEAR ANY ACFT IN THE PATTERN. I ANNOUNCED MY INTENTION TO DEPART SEZ ON RWY 21 AND TAXIED ONTO THE RWY. I DIDN'T SEE ANY TFC APCHING. AS I TAXIED ONTO THE RWY, I HEARD AN ACFT ANNOUNCE IT WAS TURNING BASE FOR RWY 03. INSTEAD OF HOLDING AT THE END OF THE RWY, I BEGAN MY TKOF ROLL, THINKING I WOULD BE OFF AND CLB OUT OVER THE PATH OF THE LNDG ACFT. THE OTHER ACFT HEARD/SAW ME AND EXECUTED A GO-AROUND, TURNING R OUT OF THE DEP PATH. BECAUSE OF THE OTHER PLT'S EVASIVE ACTION, OUR 2 ACFT REMAINED AT SAFE DISTANCES. BUT I SHOULD HAVE YIELDED THE RIGHT-OF-WAY TO THE LNDG ACFT. (LNDG ACFT WAS A HIGH FIXED WING GA ACFT). CONTRIBUTING FACTORS. I HAD JUST COMPLETED MY AFR AFTER NOT FLYING AT ALL FOR 2 YRS; MY HEAD WORK WAS RUSTY. I WAS TIRED, HAD NOT SLEPT WELL THE NIGHT BEFORE. THE SITUATION OF TFC LNDG AND DEPARTING IN OPP DIRECTIONS IS UNUSUAL. ONCE I TOOK THE RWY, I FELT COMMITTED TO TKOF, A BAD JUDGEMENT. WHAT WOULD HAVE PREVENTED THE CONFLICT. I SHOULD HAVE ASKED UNICOM FOR A TFC ADVISORY BEFORE TAXIING ONTO THE RWY, AND LOOKED MORE CAREFULLY FOR TFC IN THE PATTERN. I ALSO COULD HAVE WAITED A FEW MOMENTS AFTER ANNOUNCING MY INTENTION TO DEPART ON THE CTAF TO SEE IF ANY OTHER ACFT ANNOUNCED THEIR POSITIONS IN THE PATTERN. I COULD HAVE HELD AT THE END OF THE RWY FOR THE ARRIVING TFC TO LAND AND CLR THE RWY. ANOTHER PREVENTION, GIVEN THE UNUSUAL TFC PATTERN, WOULD HAVE BEEN TO ANTICIPATE AND DECIDE AHEAD OF TIME WHAT SAFE/UNSAFE CONDITIONS FOR TAKING OFF (VIS-A-VIS OTHER LCL TFC POSITIONS). FINALLY, NOT FLYING WHEN TIRED, IT DID SEEM TO AFFECT MY JUDGEMENT.

SYNOPSIS: CLOSE PROX GA SMA ON TKOF FROM RWY 21 AND GA SMA IN LNDG PATTERN FOR RWY 03.

REFERENCE FACILITY ID:SEZ  
FACILITY STATE: AZ  
DISTANCE & BEARING FROM REF.: , , SW  
AGL ALTITUDE: 0,500

ACCESSION NUMBER: 181915  
DATE OF OCCURRENCE: 9106  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:HPN  
FACILITY STATE: NY  
FACILITY TYPE: TWR;  
FACILITY IDENTIFIER: HPN;  
AIRCRAFT TYPE: SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL  
RQMT/PUBLISHED PROC;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: DEPARTED 6N4 ENRTE HPN. RECEIVED THE ATIS AT

ABOUT 12 NM FROM HPN (THEY WERE LNDG 34 AND 29). I CALLED HPN TWR AT 10 NM SW OF HPN AND REQUESTED THE SIERRA RTE, LNDG AT THE MAIN TERMINAL. HPN GAVE US A TRANSPONDER CODE AND CLRED US TO PROCEED INBOUND ON THE SIERRA RTE. RADIO TFC WAS VERY HVY, SO WE HAD NO FURTHER CONTACT WITH HPN TWR UNTIL I RPTED CPR X APCHING S BOUNDARY. WE WERE AT 1400 MSL PER ESTABLISHED PROC. (AN SMA WAS MOVING FROM OUR L TO R.) THE SMA WAS NOT A FACTOR, BUT I THOUGHT IT MAY HAVE LOOKED LIKE A PROBLEM FROM THE TWR. IT IS COMMON PRACTICE CALL POS AT THE ARPT BOUNDARY. TWR RESPONDED TO OUR POS RPT, 'DO YOU HAVE THE SMA ON GAR?' I DID NOT HEAR ANY REF TO RWY FROM WHICH THE GAR WAS BEING EXECUTED. I HESITATED MOMENTARILY IN REPLYING IN ORDER TO SCAN FOR THE GAR TFC. I DID NOT SEE IT. BEFORE I COULD ANSWER, OTHER RADIO TFC MADE MY REPLY IMPOSSIBLE. DURING MY VISUAL SEARCH, I SAW A LIGHT AIRPLANE MOVING ALONG, OR SLIGHTLY ABOVE, RWY 34 JUST SHORT OF 29. WE WERE NOW ABOUT OVER THE DEP END OF 29. I THOUGHT THIS LIGHT AIRPLANE MIGHT BE THE GAR TFC, BUT WAS UNSURE. STILL CONCERNED AND UNCERTAIN, I HAD RECEIVED NO FURTHER COM FROM THE TWR. I ANNOUNCED 'CPR X OVERHEAD AT 1 POINT 4.' ALMOST IMMEDIATELY THEREAFTER WE SAW THE BELLY OF SMA Y, CLBING THROUGH OUR ALT (1400 MSL) IN WHAT APPEARED TO BE A L BANK IN EXCESS OF 60 DEG IN HIS SUCCESSFUL EFFORT TO AVOID US. WE WERE, AT THAT TIME, ABOUT 1/4 MI NW OF THE INTXN OF 34 AND 29. I MAKE THE FOLLOWING OBSERVATIONS. IT SEEMS THE TWR WAS HAVING SOME DIFFICULTY IN COPING WITH THE HVY TFC, AS WE HAD NO COM WITH TWR FOLLOWING OUR INITIAL CONTACT/CLRNC UNTIL WE CALLED THEM AT THE ARPT BOUNDARY. NO TA'S WERE ISSUED UNTIL THE QUESTION 'DO YOU HAVE SMA Y ON GAR?' NO FURTHER TA'S WERE ISSUED AT ANY TIME THEREAFTER -- TO US THAT IS. I WAS NOT AWARE OF THE GAR IN PROGRESS, ALTHOUGH I PROBABLY SHOULD HAVE BEEN, AS THE OTHER PLT WITH ME SAID HE HEARD EARLIER REF TO A GAR, BUT DID NOT HEAR ANY REF TO WHICH RWY WAS INVOLVED. IMPROVED COM IN THE COCKPIT MAY HAVE HELPED. AFTER LEARNING OF THE GAR, I TOOK NO EVASIVE ACTION, AS I DID NOT KNOW WHERE THE ACFT WAS THAT I WANTED TO AVOID. I CONTINUED STRAIGHT AHEAD AND ANNOUNCED MY POS SO AS TO BE SURE MY LOCATION WAS KNOWN, WHICH SEEMED ESPECIALLY IMPORTANT SINCE I DIDN'T KNOW WHERE THE OTHER GUY WAS. I THINK IT MAY HAVE BEEN APPROPRIATE TO HAVE ISSUED US INSTRUCTIONS TO CLR THE AIRSPACE CONFLICTING WITH THE GAR. I WOULD RESTATE, HOWEVER, THAT I AM

(REPORT CONTINUED)

WELL AWARE THAT THE TWR WAS VERY BUSY, WITH A HIGH VOLUME OF TFC, AND COMS WERE A PROBLEM, GIVEN THE RADIO CONGESTION. ALTHOUGH IT MAY HAVE HAD NO IMPACT ON THIS PARTICULAR SITUATION, I SEE SOMEWHAT OF A PROBLEM WITH HAVING HELIS ENTERING ON FLT PATHS WHICH CROSS FIXED WING TFC PATTERNS WITH ONLY 100 FT VERT SEPARATION IN THE INTEREST OF NOISE ABATEMENT. IN SUMMARY, WE COULD, I THINK, HAVE BENEFITTED FROM MORE POSITIVE CTL OF THE AIRSPACE, MORE TA'S, AND PERHAPS LESS CONFLICTING TFC FLOWS. ALSO, MORE SITUATIONAL AWARENESS ON MY PART, WHICH COULD HAVE RESULTED FROM A MORE DILIGENT MONITORING OF THE RADIO AND MORE EFFECTIVE CREW COM WOULD HAVE BEEN MOST HELPFUL.

SYNOPSIS: CPR X HAD NMAC IN TFC PATTERN WITH SMA Y. SEE  
AND AVOID CONCEPT.

REFERENCE FACILITY ID:HPN

FACILITY STATE: NY

DISTANCE & BEARING FROM REF.: 0

MSL ALTITUDE: 1400,1400

ACCESSION NUMBER: 199428  
DATE OF OCCURRENCE: 9201  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; MISC,UNICOM;  
FLIGHT CONDITIONS: IMC  
REFERENCE FACILITY ID:ILN  
FACILITY STATE: OH  
FACILITY TYPE: ARPT; TRACON;  
FACILITY IDENTIFIER: ILN; DAY;  
AIRCRAFT TYPE: MLG; HVT;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; RWY  
TRANSGRESS/OTHER; NON ADHERENCE LEGAL RQMT/FAR;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: FLT WAS CLRED FOR APCH ILS TO RWY 22 AT ILN BY

DAYTON APCH CTL AND TOLD TO 'CONTACT ADVISORY'. MY FLT ROGERED  
THE CLRNC AND CALLED AIRBORNE UNICOM AND RPTED 'AIRBO INBOUND RWY  
22 WILMINGTON.' THE FLT WAS GIVEN LCL ALTIMETER AND WIND FROM  
AIRBORNE TWR. WHEN MY FLT LANDED MY FO AND I NOTICED AN HVT  
TURNING OFF AT THE FAR END OF THE 10700 FT RWY. NEITHER OF US SAW  
THE AIRPLANE ON THE RWY DURING LNDG, DUE TO THE TAIL LIGHT OF THE  
HVT BLENDING IN WITH THE CENTERLINE LIGHTS, UNTIL THE HVT TURNED  
SIDEWAYS TO US AND HE WAS TURNING OFF THE FAR END OF THE RWY. THE  
'ADVISORY TWR' DID NOT MENTION THE HVT WAS STILL ON THE RWY WHEN  
WE MADE CONTACT WITH THEM AT THE AIRBO OM. PRIOR TO REACHING  
AIRBO WE DID HEAR THE HVT CANCEL HIS IFR FLT PLAN WITH DAYTON  
APCH. WHEN I QUESTIONED THE ADVISORY ABOUT THE HVT BEING ON THE  
RWY AND TELLING ADVISORY I DIDN'T KNOW THE HVT WAS STILL ON THE  
RWY OR SEE IT UNTIL IT TURNED OFF, I WAS TOLD 'THEY WERE ONLY AN  
'ADVISORY' AND THEY DIDN'T SEE THE HVT ON THE RWY EITHER.'  
CONTRIBUTING FACTORS WERE: I HEARD THE HVT CANCEL HIS IFR WITH  
DAYTON APCH WHEN I WAS MORE THAN 7 MI FROM TOUCHDOWN. IN THE TIME  
FRAME OF BEING CLRED FOR THE ILS APCH BY DAYTON APCH AND  
CONTACTING AIRBORNE ADVISORY AT AIRBO INBOUND I FIGURED THE HVT  
WOULD HAVE BEEN OFF THE RWY. NOTHING WAS SAID TO MAKE ME THINK  
OTHERWISE. FROM NOW ON I WILL ASK ADVISORY IF THE RWY IS CLRED.

SYNOPSIS: ACR MLG FRT ACFT LANDED ON AN OCCUPIED RWY AT  
NIGHT AT A NON TWR ARPT.

REFERENCE FACILITY ID:ILN  
FACILITY STATE: OH  
AGL ALTITUDE: 0,1077

**ADVISORY PLI ELEMENTS: Incorrect Transmission, Correct Action**

ACCESSION NUMBER: 163786  
DATE OF OCCURRENCE: 9011  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:TIW  
FACILITY STATE: WA  
FACILITY TYPE: ARPT;  
FACILITY IDENTIFIER: TIW;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; UNCTRLED ARPT TRAFFIC PATTERN  
DEVIATION;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: SOME LOW STRATUS AND GND FOG WAS BEGINNING TO FORM IN THE AREA, BUT IT WASN'T A DIRECT FACTOR IN THE INCIDENT. THE TWR WAS CLOSED, SO I CALLED ON THE CTAF 8 MI OUT THAT I WAS INBND FOR STRAIGHT IN TO RWY 17. ON APPROX 4 MI FINAL ANOTHER ACFT CALLED OVER THE OM INBND ON LOW APCH. I COULD SEE ANOTHER ACFT (OR SO I THOUGHT) APPROX 3/4 MI AHEAD OF ME ON A SOMEWHAT ERRATIC APCH, BUT I COULDN'T SEE THE ACFT I ASSUMED WAS BEHIND ME THAT HAD CALLED THE OM. I KEPT UP CRUISE SPD TO PUT DISTANCE BTWN ME AND THE ACFT DOING THE ILS. I DID A COUPLE OF S-TURNS TO MAKE MYSELF MORE VISIBLE AND TO TRY TO SPOT THE PHANTOM ACFT BEHIND ME. I THEN REALIZED WHAT WAS HAPPENING. I HAD FIXED ON THE THOUGHT THAT I COULD BE RUN DOWN FROM BEHIND, WHEN ALL THE TIME THE ACFT I WAS LOOKING FOR WAS THE ONE IN FRONT OF ME. THIS REALIZATION TOOK THE FORM OF AN ACFT SILHOUETTE APPROX 50' ABOVE AND 100' AHEAD OF ME. I HAD ALMOST CAUGHT UP WITH HIM. I DID A 360 DEG TURN TO THE LEFT, AND WHEN I ROLLED OUT ON FINAL AGAIN, THE OTHER ACFT WAS JUST BEGINNING HIS MISSED APCH, COMPLETING UNAWARE OF HOW CLOSE HE CAME TO BECOMING A BIPLANE. CONTRIBUTING FACTORS TO THIS WERE FATIGUE ON MY PART, A CONCERN FOR THE GROWING AREAS OF STRATUS AND GND FOG THAT WERE FORMING, AND A FAILURE ON MY PART TO USE A STANDARD PATTERN ENTRY INSTEAD OF DOING A STRAIGHT-IN. A THOUGHT, FOR FUTURE REF, WOULD BE THAT WHEN DOING IFR PRACTICE APCHS, THE PLT OR INSTR SHOULD CALL ACTUAL POS WHEN ON CTAF, RATHER THAN WHERE THEY WERE 30 SECS OR 1 MIN AGO.

SYNOPSIS: CLOSE PROX 2 GA SMA'S IN TRAFFIC TO TIW.  
REFERENCE FACILITY ID:TIW  
FACILITY STATE: WA  
DISTANCE & BEARING FROM REF.: 1,,N  
MSL ALTITUDE: 700,700

ACCESSION NUMBER: 166711  
 DATE OF OCCURRENCE: 9012  
 REPORTED BY: FLC; ; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; TWR,LC;  
 MISC,DRIVER;  
 FLIGHT CONDITIONS: IMC  
 REFERENCE FACILITY ID:LGA  
 FACILITY STATE: NY  
 FACILITY TYPE: TWR; TRACON; ARPT;  
 FACILITY IDENTIFIER: LGA; N90; LGA;  
 AIRCRAFT TYPE: LRG;  
 ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; RWY TRANSGRESS/OTHER;  
 NON ADHERENCE LEGAL RQMT/CLNC; NON ADHERENCE LEGAL RQMT/PUBLISHED  
 PROC;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; FLC EXECUTED GAR  
 OR MAP;  
 ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
 NARRATIVE: ON SHORT FINAL, CLRED TO LAND, ILS 4 AT LGA, HAD  
 TO GO AROUND AT LESS THAN 100' AGL BECAUSE OF SNOW REMOVAL EQUIP  
 IN THE T/D ZONE. RETURNED FOR ANOTHER APCH AND LANDED W/O  
 INCIDENT. WX FOR THE APCH WAS AT MINIMUMS WITH BLOWING SNOW, FOG,  
 WINDSHEAR ALERT. PARTIALLY SNOW COVERED RWY, AND NO PREVIOUS  
 BRAKING ACTION RPTS. DURING THE APCH WE HEARD SEVERAL  
 CONVERSATIONS BTWN APCH/TWR AND THE LEADER OF THE SNOW REMOVAL  
 TEAM. TWR ADVISED THE SNOW TEAM OF OUR POS AND REQUESTED THEY GET  
 OFF THE RWY FOR OUR LNDG. APPROX 4 MI FROM T/D THE SNOW TEAM  
 LEADER RPTED TO TWR THAT INDEED HE WAS IN RADIO CONTACT WITH ALL  
 THE VEHS AND THAT ALL THE VEHS WERE CLR OF RWY 4. TWR THEN CLRED  
 US TO LAND. APPROX 2 MI FROM T/D WE THOUGHT WE SAW A STROBE LIGHT  
 IN THE R EDGE LIGHTS ADJACENT TO THE T/D ZONE. AT LESS THAN 100'  
 AGL WITH BLOWING SNOW OBSCURING MOST GND FEATURES WE SPOTTED A  
 YELLOW STATION WAGON WITH STROBE LIGHT IN THE MIDDLE OF THE T/D  
 ZONE. GO AROUND INITIATED WITH THE ACFT DSNDING TO APPROX 50'  
 OVER SAID FLEEING STATION WAGON. I DID NOT HAVE A CHANCE TO  
 DISCUSS THIS WITH THE CTLR AFTER LNDG. RECOMMENDATIONS: FOR  
 CTLR/ATC, NONE, HE DID EVERYTHING HE COULD TO ENSURE THE RWY WAS  
 CLR. FOR SNOW REMOVAL EQUIP, ENSURE STROBES ON (IT WAS THE ONLY  
 THING THAT KEPT US FROM LNDG ON TOP OF THE VEH) AND ALL VEHS  
 EQUIPPED WITH RADIOS TUNED TO TWR AND TEAM LEADER (IE, TWO  
 RADIOS). OUR COMPANY FLT SAFETY OFFICE DISCUSSED THIS EVENT WITH  
 THE LGA TWR AND ARPT MGRS. IT WAS RECOMMENDED THAT PROCS BE PUT  
 IN PLACE AT LGA TO HAVE TWR SOLICIT EARLIER ETA OF KNOW INBNDs  
 DURING SNOW REMOVAL OPS TO PREPARE SNOW REMOVAL TEAM TO CLR RWY  
 AND THAT ALL VEHS ON TEAM IS ACCOUNTED FOR WHEN CLRING; ALSO THAT  
 TEAM LEADER NOT NORMALLY LEAVE THE RADIO POST W/O POSITIVE XFER  
 TO ANOTHER LEADER.  
 SYNOPSIS: CARGO LGT SPOTTED VEHICLE ON RWY AND MADE A GO  
 AROUND. TWR NOTIFIED AND SUBSEQUENT MEETINGS HELD BETWEEN TWR ACR  
 ARPT MGR.  
 REFERENCE FACILITY ID:LGA  
 FACILITY STATE: NY  
 AGL ALTITUDE: 50,100

**ADVISORY PLI ELEMENTS: Incorrect Transmission, Incorrect Action**

None Reported

**INSTRUCTIONAL PLI ELEMENTS: Correct Transmission, Correct Action**

ACCESSION NUMBER: 76961  
DATE OF OCCURRENCE: 8710  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; TRACON,AC;  
FLIGHT CONDITIONS: IMC  
REFERENCE FACILITY ID:IAD  
FACILITY STATE: VA  
FACILITY TYPE: ARPT; TRACON;  
FACILITY IDENTIFIER: IAD; IAD;  
AIRCRAFT TYPE: WDB;  
ANOMALY DESCRIPTIONS: OTHER;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;  
NARRATIVE: LETDOWN IN IMC CONSISTING OF SOLID

STRATO-CUMULUS CLOUDS TOGETHER WITH RAINSHOWERS, EXTENSIVE RADAR VECTORS WERE RECEIVED. INBND TFC CONSISTED OF A VARIETY OF ACFT INCLUDING GA, COMMUTER AND AIRLINE TRANSPORTS. ALL WERE BEING CTLED FOR APCHS TO RWY 1R AT IAD. WX WAS RPTED AS 300-400 OVERCAST 1 1/2 MI VIS IN FOG AND RAIN. APCHING FROM THE W SOME CONCERN WAS VOICED BY OUR CREW REGARDING THE EXTENSIVE VECTORS WHICH WE WERE RECEIVING AND CONSISTED OF HDGS OF 110, 120, 180 AND 070 DEGS THROUGH THE LOCALIZER FOLLOWED BY A 90 DEG TURN TO 340 DEGS TO INTERCEPT THE 010 DEG LOCALIZER COURSE, ALL WITHIN ABOUT 17 NM OF THE ARPT. ON APCH AT ABOUT 800' WE WERE ADVISED THAT THERE WAS AN ACFT STILL ON THE RWY AND TO GAR. A LONG EXTENDED DOWNWIND VECTOR WAS GIVEN E OF THE AIRFIELD HDG S. WE WERE ASKED TO MAINTAIN A VERY SLOW 190 KTS AND LATER 170 KTS, WHICH CAUSED A MUCH GREATER FUEL BURN. APPROX ABEAM THE OM, WE WERE ADVISED THAT WE WERE #6 FOR APCH. THE VECTOR TOOK US SOME 17 NM S OF THE ARPT AND CONSUMED ABOUT 15-20 MINS TIME. OUR TURN TO FINAL WAS BEHIND AN SMT WITH A RPTED GND SPD OF 90 KTS. AS WE APCHED THE OM THE CTLR BEGAN TO BECOME CONCERNED AND ADVISED US THAT OUR AIRSPD WAS 60 KTS, FASTER THAN THE PRECEEDING ACFT. THEN WITHIN A FEW MI OF THE OM, WE WERE ASKED IN A SOMEWHAT FRENZIED MANNER, IF WE COULD TAKE RWY 1L! THIS CAME AS AN UNEXPECTED SHOCK. WE HAD BRIEFED AND PLANNED FOR RWY 1R APCH AND WITH THE HIGH WORKLOAD IN IMC TOGETHER WITH SOME ACFT IRREGULARITIES, A SUDDEN SHIFT TO ANOTHER RWY WAS VERY PERPLEXING AND DIFFICULT TO HANDLE. WE WERE ABLE TO ADEQUATELY ACCOMMODATE THE REQUEST, BUT IT WAS VERY DISTRACTING AND DEGRADED THE OPERATION FROM BEING AS SAFETY EFFICIENT AS IT COULD HAVE BEEN. A DIVERSION TO OUR ALTERNATE WOULD HAVE BEEN REQUIRED HAD WE BEEN UNABLE TO ADJUST TO THE SITUATION. LATER THE OPERATION WAS DISCUSSED WITH THE APCH CTL SUPVR AND WE WERE NOT SATISFIED WITH THE PROBABLE REASONS FOR THE PROBLEMS, SUCH AS WIND SHEARS AT DIFFERENT LEVELS CAUSING DIFFICULTY IN SPACING ACFT, ETC. THERE SEEMS TO BE A MUCH BROADER PROBLEM THAT MAY NOT BE APPARENT TO THOSE VERY NEAR THE ISSUES, SUCH AS THE SUPVR. THESE ISSUES MAY VERY WELL INVOLVE THE SUDDEN GROWING UP OR COMING OF AGE OF DULLES INT'L ARPT AND THE DRAGGING

(REPORT CONTINUED)

BEHIND OF MANY IMPORTANT ASPECTS OF TOP NOTCH, CRISP AND HIGHLY PROFESSIONAL SVCS THAT SHOULD BE SUPPORTING THIS ARPT TODAY, INCLUDING LCL ATC RADAR SVCS AND THE WAY THEY DO BUSINESS. I HAD ADDED 4000# OVER AND BEYOND COMPANY/DISPATCH PLANNING. THIS PROVED TO BE THE MARGIN NECESSARY TO AVOID AN ALTERNATE OPERATION IN THIS INSTANCE. WHY WAS IT NECESSARY TO INITIALLY BE VECTORED BY SUCH LARGE HDG CHGES (1 TOTAL REVERSAL OVERALL WAS 200 DEGS AND INCLUDING A PERPENDICULAR VECTOR THROUGH THE LOCALIZER SO CLOSE TO THE ARPT? AFTER OUR ORIGINAL MISSED APCH, WHY DID THE NEW CTLR THAT VECTORED US BACK FOR ANOTHER APCH NOT HAVE INFO THAT WE WERE A MISSED APCH ACFT? THIS FACTOR WAS REVEALED BY THE APCH CTL SUPVR AND WOULD HAVE BEEN A VITAL CONSIDERATION TO THE NEW CTLR REGARDING POSSIBLE LOW FUEL CONSIDERATIONS AND SPACING ON PRECEEDING ACFT, SO AS TO INSURE AS MUCH AS POSSIBLE A COMPLETED LNDG ON THE SECOND ATTEMPT. OUR FUEL USED DURING THIS MISSED APCH, VECTOR AND NEW APCH WAS ABOUT 4000-4500#. WHAT HUMAN FACTOR ISSUES CAME INTO PLAY THAT CAUSED THE FINAL CTLR TO POS OUR ACFT IN SUCH A MANNER THAT A SECOND GAR WOULD HAVE BEEN NECESSARY NEAR THE 1R OM, DUE TO OUR RAPIDLY OVERTAKING VERY SLOW PRECEEDING ACFT? WAS THERE ADDITIONAL AIRSPACE TO MANEUVER THAT OUR FLT COULD HAVE USED? COULD LOW CTLR EXPERIENCE LEVELS IN THE CTL OF A MIX OF ACFT REQUIRING RELATIVELY SLOW TO HIGH MANEUVER AND APCH SPDS HAVE BEEN A FACTOR? MORE ADVANCE NOTICE FOR RWY CHGES UNDER SUCH CIRCUMSTANCES IS ESSENTIAL FOR THE HIGHEST SAFETY AND OPERATIONAL EFFICIENCIES. WHAT GUIDLINES ARE NORMAL, PRACTICAL AND IN THE BEST INTEREST OF SAFETY, WHEN DECIDING TO SUDDENLY SWITCH RWYS UNDER SUCH CIRCUMSTANCES. FINALLY, IF TFC AT DULLES IS INCREASING TO SUCH AN EXTENT THAT EXTENSIVE VECTORIZING IS BECOMING NECESSARY, WOULD IT NOT BE REASONABLE THAT THE N/S APCHS BE UPGRADED TO ACCOMMODATE SIMULTANEOUS INSTRUMENT APCHS? IN THIS REGARD, WOULD IT NOT BE FURTHER BENEFICIAL TO PREDOMINANTLY ASSIGN GA AND SLOW COMMUTER AND AIR TAXI ACFT TO 1 RWY WHILE THE OTHER RWY HANDLES BUSINESS JETS AND AIR TRANSPORT ACFT?

SYNOPSIS: COMPLAINT ABOUT APCH CTLR HANDLING AT IAD. WX

WAS IMC AND GO AROUND ISSUED AT 800' DUE ACFT STILL ON RWY.

REFERENCE FACILITY ID:IAD

FACILITY STATE: VA

DISTANCE & BEARING FROM REF.: 3,,SO

MSL ALTITUDE: 800,3000

ACCESSION NUMBER: 85529  
DATE OF OCCURRENCE: 8804  
REPORTED BY: FLC; ; ; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TWR, GC;  
TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:BOS  
FACILITY STATE: MA  
FACILITY TYPE: TWR; ARPT;  
FACILITY IDENTIFIER: BOS; BOS;  
AIRCRAFT TYPE: LRG; SMT;  
ANOMALY DESCRIPTIONS: OTHER; CONFLICT/GROUND LESS SEVERE; LESS THAN  
LEGAL SEPARATION;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: OTHER;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: GND CTL CLRED US TO CROSS 4L AND CONTACT TWR ON

OTHER SIDE. WE ACKNOWLEDGED THE CLRNC AND INITIATED THE TAXI. WE  
DID NOT OBSERVE A LNDG ACFT WHICH WAS ON L TURN TO FINAL UNTIL  
OUR ACFT WAS ON THE RWY. POSSIBLY DUE TO THE ANGLE OF THE APCHING  
ACFT AND OUR VANTAGE POINT. F/O CALLED ATTENTION TO APCHING ACFT,  
AT SAME TIME AS CAPT OBSERVED SAME. AS THE ACFT COMPLETED ITS  
TURN TO FINAL, CAPT APPLIED ADDITIONAL PWR TO FURTHER EXPEDITE  
CROSSING. CALLBACK CONVERSATION WITH RPTR REVEALED THE FOLLOWING  
INFO: OTHER ACFT WAS AN SMT ON APCH TO RWY 4L AND WAS ON A CLOSE  
PATTERN. RPTR THINKS THE SMT FLEW A MUCH TIGHTER BASE AND FINAL  
THAN GND CTLR HAD EXPECTED. AT A LATER DATE HE WAS ON A HARBOR  
CRUISE AND SAW AN SMT DO THE SAME THING WITH A VERY TIGHT  
PATTERN. THE SMT DID NOT GO AROUND, IN FACT, LGT GOT ON TWR FREQ  
IN TIME TO HEAR LCL CTLR TELL SMT OK TO LAND THAT THE RWY WAS CLR  
SO SMT AND TWR WERE ALL AWARE OF SITUATION AND READY TO TAKE  
ALTERNATE ACTION.

SYNOPSIS: ACR LGT CLEARED ACROSS ACTIVE WITH ACR SMT ON  
CLOSE IN CIRCLING APCH WITH LESS THAN GOOD SEPARATION.  
REFERENCE FACILITY ID:BOS  
FACILITY STATE: MA  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 100348  
DATE OF OCCURRENCE: 8812  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TWR,LC;  
FLIGHT CONDITIONS: IMC  
REFERENCE FACILITY ID:TPA  
FACILITY STATE: FL  
FACILITY TYPE: TRACON; TWR; ARPT;  
FACILITY IDENTIFIER: TPA; TPA; TPA;  
AIRCRAFT TYPE: MLG;  
ANOMALY DESCRIPTIONS: OTHER;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/ANOMALY ACCEPTED;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;

NARRATIVE: APCH CTL TURNED US OVER TO TWR. WE CALLED WITH NO RESPONSE FROM TWR. WE WERE ON INSTRUMENTS INSIDE THE OM. WE CALLED AGAIN; NO LUCK. WE CALLED GND CTL; NO LUCK. WE CALLED APCH CTL AGAIN; NO LUCK. WE THEN CALLED THE TWR AGAIN; NO LUCK. I THEN CALLED THE TWR AND SAID, "IF YOU READ ME, GIVE ME A LIGHT." STILL NO LUCK. AT THIS TIME AN ACR FLT ANSWERED MY CALL AND SAID THEY READ US AND THAT TWR WAS OFF THE AIR. WE NOW HAD RWY 36 IN SIGHT AND I LANDED W/O CLRNC. ALL THE ABOVE OCCURRED IN LESS THAN A MINUTE. I ELECTED TO LAND AS I HAD RWY 36 IN SIGHT. NO ACFT WERE ON THE RWY AND A GAR WOULD HAVE PUT ALL MISSED APCH ACFT AT THE SAME MISSED APCH FIX AND AT THE SAME ALT WITH NO ATC CTL, AS IT WAS THEIR RADIOS THAT WERE OUT. AFTER LNDG, CONTACT WAS MADE WITH GND CTL WHO TOLD ME THAT A MASTER SWITCH WAS SHUT OFF, TURNING OFF TWR, APCH AND GND CTL.

SYNOPSIS: UNABLE TO CONTACT TWR FOR LNDG CLRNC.  
REFERENCE FACILITY ID:TPA  
FACILITY STATE: FL  
DISTANCE & BEARING FROM REF.: 5,,SO  
MSL ALTITUDE: 2000,2000

ACCESSION NUMBER: 102921  
DATE OF OCCURRENCE: 8901  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SJC  
FACILITY STATE: CA  
FACILITY TYPE: ARPT; TWR; TWR;  
FACILITY IDENTIFIER: SJC; SJC; SJC;  
AIRCRAFT TYPE: LTT; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: OUR ACFT POS AND HOLD RWY 30L SJC. AN SMA WAS

CLRED FOR TKOF RWY 30R AND TOLD TO TURN LEFT BEHIND DEPARTING LTT. WE WERE CLRED TO DEPART AND WERE TOLD BY TWR THAT THE DEPARTING SMA WOULD TURN BEHIND US. THE OTHER ACFT WAS AIRBORNE BEFORE WE STARTED OUR TKOF ROLL. THE SMA WAS AGAIN TOLD TO TURN BEHIND US, "THE LTT." THE PLT APPARENTLY BECAME CONFUSED AND TURNED INTO US. I ADVISED THE CAPT LOUDLY OF THE CLOSING TFC. ADVISED A RIGHT TURN AND APPLIED PRESSURE TO THE FLT CONTROLS TO AVOID COLLISION. THE OTHER PLT MAY HAVE MISTAKEN THE LIGHTS OF A MUCH LARGER JET A FEW MI OFF THE DEP END FOR OUR AIRPLANE. THE AVERAGE PLT SHOULD NOT BE EXPECTED TO IDENT SPECIFIC ACFT TYPES IN THE DARK! ALSO, IT WAS A BUSY NIGHT AT SJC. TFC WAS CONSTANTLY ARRIVING AND DEPARTING OFF THE LEFT RWY. IN MY OPINION, TFC REQUESTING A LEFT TURN OFF THE RIGHT RWY UNDER THESE CONDITIONS SHOULD BE ISSUED A CLRNC FOR A RIGHT 270 DEG CLBING TURN OVERHEAD. A MORE TIMELY DEP FOR EITHER ACFT WOULD HAVE SOLVED THE PROB. MORE SPECIFIC PHRASEOLOGY BY THE TWR DIRECTED TO THE SMA MAY HAVE HELPED ALSO. I AM THANKFUL THE TWR INFORMED US BOTH DIRECTLY AND INDIRECTLY (WE COULD HEAR THE TWR CALL THE SMA) OF THE SMA'S INTENTIONS. AFTER BEING SO ALERTED, I WATCHED THE TFC CLOSELY THROUGHOUT THE TKOF. HAD I NOT BEEN CONCENTRATING ON THE SMA LIGHTS, THE SMA SLOW TURN MIGHT HAVE BEEN IMPERCEPTIBLE WITH PERIPHERAL VISION. THE PIC DID NOT SEE THE TFC BEFORE I CALLED IT. I BELIEVE WE WOULD HAVE HIT THE AIRPLANE W/O EVASIVE ACTION.

SYNOPSIS: CLOSE PROX CPR-LTT GA-SMA DURING ICB FROM  
PARALLEL RWYS.

REFERENCE FACILITY ID:SJC  
FACILITY STATE: CA  
AGL ALTITUDE: 0,500

ACCESSION NUMBER: 104390  
DATE OF OCCURRENCE: 8902  
REPORTED BY: FLC; DISP;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; MISC,DISP;  
FLIGHT CONDITIONS: IMC  
REFERENCE FACILITY ID:PIT  
FACILITY STATE: PA  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: PIT; PIT;  
AIRCRAFT TYPE: MLG; LTT;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; LESS THAN LEGAL SEPARATION;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: OTHER;

NARRATIVE: 28C TKOF WITH CLRNC, "TURN LEFT TO HDG 200 DEGS." CAME IN CONFLICT WITH TWIN ENG PROP WHO HAD MISSED APCH ON 28L. ROLLED OUT OF TURN BACK TOWARD RWY HDG AND INFORMED TWR. WE HEARD THE OTHER ACFT CALL MISSED APCH AND RECEIVE INSTRUCTIONS TO CLB TO 3000'/RWY HDG. WE SAW THE ACFT CONFLICTING WITH OUR COURSE AND TOOK APPROPRIATE ACTION. WE PASSED WITHIN 200'. SUPPLEMENTAL INFO FROM ACN 104402: OUR CREW UNDERSTOOD THE TWR TO HAVE GIVEN THE LIGHT ACFT A MISSED APCH PROC OF MAINTAIN RWY HDG TO 3000'. OUR CREW DID TELL THE TWR, HOWEVER, THEY DIDN'T SEEM TO THINK THERE WAS A PROB.

SYNOPSIS: CLOSE PROX ACR-MLG GA-LTT IN PIT ATA.

REFERENCE FACILITY ID:PIT  
FACILITY STATE: PA  
DISTANCE & BEARING FROM REF.: 1,,W  
AGL ALTITUDE: 450,500

ACCESSION NUMBER: 109866  
DATE OF OCCURRENCE: 8904  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,ISTR; FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:BMI  
FACILITY STATE: IL  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: BMI; BMI;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC EXECUTED GAR OR MAP;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: ON AN INSTRUMENT FLT PLAN WAS HANDED OFF FROM  
PEORIA, IL, APCH TO BMI TWR, AND TOLD RPT MISIE INBND TO BMI TWR.  
WE WERE CLRED TO LAND UPON RPTING MISIE. I HEARD THE CTLR (BMI  
TWR) CLR AN SMA X TO LAND AND AN SMA Y TO DEPART. I HAD A VIS ON  
THE DEPARTING TFC, BUT NO VIS ON THE SMA X. MY STUDENT WAS  
CENTERED ON THE ILS AND WAS TRACKING IT WELL SO I COULD SCAN FOR  
TFC. ABOUT 1700' MSL THE SMA X APPEARED AT 2 O'CLOCK AND APPROX  
1/8 OF A MI. THE SMA X APPEARED TO HAVE SEEN US AND WAS RUSHING  
TO GET IN FRONT OF US. THE SMA X THEN TURNED IN FRONT OF US AND  
CONFIGURED FOR A LNDG AT WHICH TIME I CALLED A GO AROUND AND TOOK  
THE ACFT FROM THE STUDENT. IT SEEMS TO ME THAT THE SMA PLT WAS IN  
A HURRY TO GET IN FRONT OF OUR ACFT WHICH WAS SLOWED UP IN AN IFR  
APCH CONFIGN (STABILIZED AT 90 KTS). THE SMA X PLT'S PERFORMANCE  
INDICATED A LACK OF PLANNING OR SAFETY.

SYNOPSIS: CLOSE PROX GA-SMA ON PRACTICE ILS APCH AND  
GA-SMA ENTERING TRAFFIC PATTERN.

REFERENCE FACILITY ID:BMI  
FACILITY STATE: IL  
DISTANCE & BEARING FROM REF.: 1,,E  
MSL ALTITUDE: 1700,1700

ACCESSION NUMBER: 112175  
DATE OF OCCURRENCE: 8905  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:OMA  
FACILITY STATE: NE  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: OMA; OMA;  
AIRCRAFT TYPE: SMT; SMT;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;  
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
ANOMALY RESOLUTION: FLC EXECUTED GAR OR MAP; CTLR ISSUED NEW CLNC;  
ANOMALY CONSEQUENCES: NONE;  
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;

NARRATIVE: THE F/O WAS CONDUCTING A VIS APCH TO RWY. "FLAPS FULL" WERE CALLED FOR AT THE APPROPRIATE TIME--LNDG A-SYRED. THE LCL CTLR THEN CLRED ANOTHER SCHEDULED ACR (COMMUTER) FOR TKOF W/O DELAY ON RWY 35. THE DEP ACFT WAS NOT YET AT THE RWY ENTRANCE AND STILL HAD AN ESTIMATED 50' TO THE RWY. THE OTHER PLT ACKNOWLEDGED HIS DEP CLRNC. I COMMENTED TO MY F/O THAT THIS WAS NOT GOING TO WORK AND ADVISED HIM TO BE PREPARED FOR A GAR. OUR APCH WAS CONTINUED UNTIL WE WERE OVER THE APCH END OF THE RWY 100'. I ANTICIPATED THE LCL CTLR TO CANCEL TKOF CLRNC OF THE OTHER ACFT. INSTEAD WE WERE INSTRUCTED TO GO AROUND WITH NO SPECIFIC INSTRUCTIONS. THE F/O INITIATED THE PROC, I INDICATED FOR HIM TO TURN RIGHT TO 350 DEGS SO THAT I COULD KEEP IN VIEW THE OTHER ACFT. THE OTHER ACFT WAS AIRBORNE BEAM THE TWR AS WERE WE. WE WERE LIMITED TO TURNING FURTHER RIGHT BECAUSE OF THE ELEVATED TERRAIN. THIS HAS NOT BEEN THE FIRST TIME AT OMA--JUST THE CLOSEST!! IT HAS TO STOP, REGARDLESS OF TRNING (ATC) OR OTHERWISE.

SYNOPSIS: CLOSE PROX COMMUTER SMT ON SHORT FINAL AND  
COMMUTER SMT ON TKOF ROLL.

REFERENCE FACILITY ID:OMA  
FACILITY STATE: NE  
AGL ALTITUDE: 100,400

ACCESSION NUMBER: 115635  
DATE OF OCCURRENCE: 8907  
REPORTED BY: FLC; ; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:GEB  
FACILITY STATE: WA  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: GEG; GEG;  
AIRCRAFT TYPE: MLG; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC EXECUTED GAR OR MAP;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: WE WERE CONDUCTING A VISUAL APCH TO RWY 3,  
CLEARED TO LAND. A LIGHT ACFT WAS CLEARED TO LAND ON INTERSECTING  
RWY 7 "HOLD SHORT OF RWY 3". THE SMA DOVE FOR THE THRESHOLD AND  
WAS IN MARGINAL CONTROL OF ACFT AND IT APPEARED VERY DOUBTFUL  
THAT HE COULD, IN FACT, HOLD SHORT OF RWY 3. WE EXECUTED A MISSED  
APCH TO AVOID PROBABLE COLLISION.  
SYNOPSIS: ACR MLG MADE GO AROUND TO AVOID SMA THEY THOUGHT  
WOULD NOT BE ABLE TO HOLD SHORT OF INTERSECTING RWY.  
REFERENCE FACILITY ID:GEB  
FACILITY STATE: WA  
DISTANCE & BEARING FROM REF.: 1,,SW  
AGL ALTITUDE: 400,400

ACCESSION NUMBER: 121909  
 DATE OF OCCURRENCE: 8909  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TWR,LC;  
 FLIGHT CONDITIONS: MXD  
 REFERENCE FACILITY ID:CLE  
 FACILITY STATE: OH  
 FACILITY TYPE: ARPT; TWR;  
 FACILITY IDENTIFIER: CLE; CLE;  
 AIRCRAFT TYPE: ; ;  
 ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; OTHER; LESS THAN  
 LEGAL SEPARATION;  
 ANOMALY DETECTOR: ATC/CTLR; COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC EXECUTED GAR OR MAP; CTLR ISSUED NEW CLNC;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: WE WERE MAKING AN INSTRUMENT APCH TO CLEVELAND  
 23L AND WERE ASKED TO SIDESTEP TO THE 23R. THE WX ON THE APCH DID  
 NOT ALLOW US TO SIDESTEP BECAUSE OF A HEAVY RAIN STORM. WE COULD  
 NOT SEE EITHER RWY. THE TWR HAD TAXIED ACR Y ONTO 23L FOR TKOF,  
 THEY THEN DECIDED THAT I WOULD NOT BE ABLE TO SIDESTEP SO THEY  
 ASKED ACR Y TO TAXI OF 23L. I HEARD ON THE RADIO WHAT WAS GOING  
 ON AND AS I CAME INTO THE CLEAR I SAW ACR Y WAS TURNING TO CLEAR  
 THE RWY. AT THIS TIME I LEVELED OFF ABOVE DECISION HEIGHT AND  
 STARTED TO MAKE A GO AROUND. I WAS WAITING FOR THE TWR TO ORDER A  
 GO AROUND, BUT THEY NEVER DID. AS I CONTINUED ON THE GO AROUND  
 AND FLEW OVER ACR Y, THE TWR THEN SAW I WAS CLEAR, SO THEY THEN  
 GAVE ME ORDERS TO LAND ON 23L. WX DID NOT PERMIT ME TO SIDESTEP.  
 ACFT WAS TAXIED INTO POSITION FOR TKOF BEFORE THEY KNEW I COULD  
 SIDESTEP. TWR CTLR WAS A TRAINEE.  
 SYNOPSIS: COMMUTER ACFT MADE GO AROUND WHEN THEY WERE  
 UNABLE TO SIDESTEP TO PARALLEL RWY AS CLEARED.  
 REFERENCE FACILITY ID:CLE  
 FACILITY STATE: OH  
 DISTANCE & BEARING FROM REF.: 2,,NE

ACCESSION NUMBER: 142265  
DATE OF OCCURRENCE: 9004  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID: BTV  
FACILITY STATE: VT  
FACILITY TYPE: TWR; ARPT;  
FACILITY IDENTIFIER: BTV; BTV;  
AIRCRAFT TYPE: MLG; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; CTLR INTERVENED;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: WAS IN POS AND HOLDING FOR TKOF ON RWY 33 AT

BTV. LIGHT ACFT WAS IN THE PATTERN ON RWY 01 DOING LEFT PATTERNS. AFTER LIGHT ACFT COMPLETED HIS TOUCH AND GO ON RWY 01, HE WAS GIVEN CLRNC FOR ANOTHER PATTERN WITH A RIGHT TURN TO A RIGHT BASE, AND WE WERE CLRED FOR TKOF WITH THE COPLT MAKING THE TKOF. AS WE WERE PASSING 100 KTS I NOTICED THE LIGHT ACFT MAKING A LEFT TURN TOWARD THE DEP END OF OUR RWY AT AN ALT OF 400-500' AGL. AS WE WERE MOVING RAPIDLY AND I HAD CLR VIS CONTACT, I NOTIFIED THE F/O OF THE PROB, TOLD HIM TO CONTINUE AND MAKE A VERY SHALLOW CLBOUT. AS WE LIFTED OFF TWR NOTIFIED THE LIGHT ACFT OF THIS WRONG TURN AND VERIFIED THAT WE HAD VIS SEP. WE PASSED DIRECTLY UNDERNEATH THE OTHER ACFT BY ABOUT 200'. IF VIS CONTACT HAD NOT BEEN ESTABLISHED, A MIDAIR WOULD HAVE BEEN A HIGH PROBABILITY. FROM MY OBSERVATION POINT, ALL PARTIES WERE COMPLYING WITH STANDARD PROCS, UP TILL THE TIME THAT THE LIGHT ACFT TURNED TO A LEFT INSTEAD OF RIGHT BASE. I SUSPECT TRNING WAS GOING ON AND BEING A QUIET SUNDAY MORNING THE OTHER ACFT WAS USED TO LEFT TURNOUTS AND UNCONSCIOUSLY CONTINUED IN ITS ESTABLISHED ROUTINE. FORTUNATELY FOR US, IT WAS A CLEAR DAY AND WE SAW THE OTHER ACFT WITH PLENTY OF TIME TO SPARE. THERE IS ALSO A STRONG POSSIBILITY THAT TWR'S CALL WOULD ALSO HAVE HELPED US IF WE HAD NOT NOTICED THE OTHER ACFT A FEW SECS EARLIER. THE KEY HERE WAS SITUATIONAL AWARENESS. WE WERE VERY MUCH AWARE OF THE OTHER ACFT WITH TWR, HOWEVER THE OTHER PARTY NOT ONLY MADE A WRONG TURN, BUT ALSO THE CLR FOR TKOF CALLS ON RWY 33 WHICH SHOULD HAVE WARNED HIM THAT TURNING THAT WAY AT 500' AGL WOULD BE A PROB.

SYNOPSIS: SMA PLT DID NOT COMPLY WITH INSTRUCTIONS FROM TWR LCL CTLR. HE TURNED LEFT DOWNWIND INSTEAD OF A RIGHT DOWNWIND PATTERN. PREVIOUS PATTERN WAS LEFT DOWNWIND--HOWEVER, TWR CHANGED TO RIGHT PATTERN TO ALLOW THE MLG TO DEPART TO THE NORTHWEST. RIGHT DOWNWIND WOULD HAVE TAKEN THE SMA BEHIND THE DEP.

REFERENCE FACILITY ID: BTV  
FACILITY STATE: VT  
DISTANCE & BEARING FROM REF.: 1, ,NW  
MSL ALTITUDE: 200,200

ACCESSION NUMBER: 142920  
DATE OF OCCURRENCE: 9004  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,PIC.CAPT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:EWR  
FACILITY STATE: NJ  
FACILITY TYPE: TWR;  
FACILITY IDENTIFIER: EWR;  
AIRCRAFT TYPE: LRG; LRG;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; FLC EXECUTED GAR  
OR MAP;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: ACR X TKOF WAS BEING MADE ON RWY 4R AT EWR. ACR  
Y HAD PREVIOUSLY BEEN CLRED TO LAND ON RWY 29 AT SAME ARPT. THE 2  
DESCRIBED RWYS DO NOT INTERSECT, SO NO PROB WAS ANTICIPATED. ALL  
MEMBERS OF THE CREW WERE AWARE OF AND MONITORING THE DEVELOPMENT  
OF THE SITUATION. THE TKOF WAS CONTINUED. JUST AFTER LIFTOFF ACR  
Y ANNOUNCED HE WAS GOING AROUND. AT 150' OF ALT, BOTH ACFT MADE  
STEEP LEFT TURN TO AVOID EACH OTHER.  
SYNOPSIS: ACR X HAD AIRBORNE CONFLICT LESS SEVERE WITH ACR  
Y IN ATA.  
REFERENCE FACILITY ID:EWR  
FACILITY STATE: NJ  
DISTANCE & BEARING FROM REF.: 0  
MSL ALTITUDE: 150,150

ACCESSION NUMBER: 145775  
DATE OF OCCURRENCE: 9005  
REPORTED BY: FLC; FLC; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:ORD  
FACILITY STATE: IL  
FACILITY TYPE: TWR; TRACON; ARPT;  
FACILITY IDENTIFIER: ORD; ORD; ORD;  
AIRCRAFT TYPE: WDB; BMB;  
ANOMALY DESCRIPTIONS: TRACK OR HDG DEVIATION; OTHER; NON ADHERENCE  
LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: FLC RETURNED ACFT TO ORIGINAL CLNC OR INTENDED  
COURSE;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: ATIS STATED APCHS WERE BEING MADE TO 27L AND 27R. APCH CLRED US FOR WHAT WE THOUGHT WAS A VIS APCH TO 27L. THE CAPT FELT THAT WE HAD READ BACK 27L AND I WAS ALSO UNDER THE IMPRESSION HE HAD. UPON XING THE FINAL COURSE OF 32L, THE CTLR CALLED AND SAID WE SHOULD BE GOING TO 32L. HE THEN TURNED US LEFT TO A HDG THAT PUT US ON A RIGHT BASE FOR 32L. THERE WAS NO TFC CONFLICT AT THIS POINT. PRIOR TO TURNING FINAL TO 32L, WE NOTICED A BOMBER ON A CLOSE-IN PATTERN BEGIN A LEFT TURN FOR LNDG INSIDE OF US. WE CONTINUED ON OUR BASE HDG AND WERE VECTORED BACK FOR AN UNEVENTFUL APCH AND LNDG ON 32L. THERE WERE A FEW FACTORS LEADING TO OUR OVERSHOOT. 1) ATIS WAS SAYING THAT LNDG ACFT WERE USING 27L AND 27R WITH NO MENTION OF 32L. 2) WE WERE HANDED OFF TO APCH TO 121.15. AFTER SEVERAL ATTEMPTS OF CALLING ON THIS FREQ WITH NO REPLY, WE WENT BACK TO OUR PREVIOUS FREQ. HE AGAIN TOLD US TO TRY 121.15. STILL NO LUCK. AFTER RETURNING AGAIN TO OUR PREVIOUS FREQ, WE WERE GIVEN 125.7. SHORTLY THEREAFTER WE WERE AGAIN HANDED TO APCH ON 121.15 WITH 2-WAY COMS FINALLY ESTABLISHED. THIS PARTICULAR PROB TOOK A CONSIDERABLE AMOUNT OF TIME. DUE TO ALL THE SWITCHING BACK AND FORTH, NEITHER THE CAPT NOR I HEARD ANY OF THE CTLRS TELL US A PARTICULAR RWY TO EXPECT, WHICH IS HIGHLY UNUSUAL AT ORD. 3) AT ONE POINT, WE WERE GIVEN AN 090 DEG HDG, WHICH WOULD BE APPROPRIATE FOR A DOWNWIND TO 27L. IN ADDITION TO THE OVERSHOOT SITUATION, I WOULD LIKE TO COMMENT ON THE TWR SITUATION WITH THE BMB. ON APCH, I HEARD THE CTLR TELL WHAT I UNDERSTOOD TO BE THE BMB THAT HE COULD ONLY HAVE A STRAIGHT IN, FULL STOP LNDG. SINCE THE BMB WAS NOT ON VHF, I DID NOT HEAR HIS XMISSION, BUT THE CTLR RESTATED HE COULD ONLY HAVE A STRAIGHT IN, FULL STOP LNDG, SO WE WERE PRETTY SURPRISED TO SEE HIM ON A CLOSE IN LEFT DOWNWIND AFTER A TOUCH AND GO. I DON'T THINK THE TWR CTLR WAS EXPECTING US ON 32L. I SINCERELY BELIEVE WE WERE INITIALLY AT LEAST BEING VECTORED TO 27L. I WOULD LIKE TO MAKE ONE RECOMMENDATION: I THINK ALL ACFT UTILIZING LARGE ARPTS SUCH AS ORD SHOULD BE REQUIRED TO HAVE VHF CAPABILITY, AND MORE IMPORTANTLY, USE IT.

SYNOPSIS: FLT CREW OF ACR WDB ON APCH INTO ORD MISTAKENLY BELIEVES THAT THEY ARE CLEARED FOR 27L UNTIL CTLR TELLS THEM THEY ARE SUPPOSED TO LINE UP WITH 32L. AFTER GETTING THAT PROBLEM RESOLVED, THE FLT CREW FEELS THAT THEY ARE TOO CLOSE TO A LNDG

(REPORT CONTINUED)

BMB AHEAD OF THEM AND ASKS FOR VECTORS BACK FOR ANOTHER VISUAL  
APCH.

REFERENCE FACILITY ID:ORD

FACILITY STATE: IL

DISTANCE & BEARING FROM REF.: 5,,SE

MSL ALTITUDE: 4000,4000

ACCESSION NUMBER: 149191  
DATE OF OCCURRENCE: 9006  
REPORTED BY: FLC; ; FLC; FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; ARTCC,RDR; ARTCC,RDR;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID: LNY  
FACILITY STATE: HI  
FACILITY TYPE: ARTCC;  
AIRCRAFT TYPE: WDB; MLG;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL  
SEPARATION; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: NOT RESOLVED/INSUFFICIENT TIME;  
ANOMALY CONSEQUENCES: FAA INVESTIGATORY FOLLOW-UP; FLC/ATC REVIEW;  
NARRATIVE: ACR X CLRED DIRECT LANAI VOR WITH A JULLE 1 ARR

INTO HNL. APCHING MAUI WE WERE CLRED TO FL220. PAST MAUI WE WERE CLRED TO 16000' AND 280 KTS AIRSPD. (CENTER FREQ, 120.6). APCHING LANAI VOR WE WERE CLRED TO CENTER FREQ 119.3. AT THIS IDENTICAL TIME WE OBSERVED A JET APCHING US SLIGHTLY LOWER AND SLIGHTLY LEFT. FREQ 119.3 WAS CONGESTED WHEN WE CAME ON, BUT WE HEARD THE CENTER GIVING AN ACR FLT A 20 DEG LEFT TURN. AT THIS TIME THE JET WE HAD BEEN OBSERVING TURNED TOWARD US AND PASSED ABOUT 1/2 MI TO OUR LEFT AT OUR ALT. IT WAS ACR Y. I CONTACTED ZHN ON ARR AND WAS ADVISED THEY WERE WELL AWARE OF THE SITUATION AND WERE LOOKING INTO IT. THE ACR Y PLT ADVISED CENTER HE HAD NOT SEEN ACR X. IT WOULD BE MY OPINION THAT ZHN TURNED ACR Y INTO US RATHER THAN AWAY AND WE WERE NOT GIVEN ANY TURNS OR TFC NOTIFICATION ON EITHER CENTER FREQ. THE CHANGE OF FREQ AT THAT INSTANT COMPOUNDED THE SITUATION. SUPPLEMENTAL INFO FROM ACN 149310: ENRTE TO ITO FROM HNL IN A CLB TO FL230, ATC ON 2 OCCASIONS REQUESTED A LEFT TURN, FIRST OF 10 DEGS, THEN 20 DEGS FOR TFC. ORIGINALLY CLRED TO GO DIRECT TO PUMIC INTXN. N OF HILO 101 DEG COURSE FROM JUST W OF MOLOKAI, ATC HAD US GOING ABOUT 071 DEGS. BY THE TIME WE GOT TO MAUI (POINT OF INCIDENT) AT FL220 CENTER CALLED AND SAID TO DSND TO FL210 IMMEDIATELY! EXACTLY AT SAME TIME I LOOKED OUT CAPT'S WINDSCREEN TO N. I SAW ACR X PASSING WHAT SEEMED TO BE LESS THAN 1/4 MI AT SAME ALT. UNABLE TO REACT IN TIME. WE PROCEEDED TO HILO WITH NO FURTHER INCIDENT. UPON LNDG AT HILO. I CALLED ZHN AND INQUIRED AS TO WHAT HAD HAPPENED. THE SUPVR INDICATED TO ME THAT THEY HAD LOST RADAR CONTACT WITH ACR X AND ACR X HAD FAILED TO ANSWER SEVERAL CALLS. THE CTLR HAD BEEN REMOVED FROM HIS SCOPE. AN OPERORR WAS BEING FILED. ALSO THE ACR X CREW SAID THEY SAW US (AS I CALLED THEM ALSO AT THEIR OPS RAMP OFFICE), BUT I DIDN'T SEE THEM TRY TO DEVIATE AT ALL! CALLBACK CONVERSATION WITH RPTR REVEALED THE FOLLOWING: RPTR STATED THAT QUALITY ASSURANCE AT ZHN SAID THAT CTLR TRNING WAS IN PROGRESS. THE SECTOR WORKING ACR X AND Y WAS WORKING WITH OVERLAPPING RADAR SITES. RPTR STATED THE CAPT OF ACR X SAID HE STARTED A TURN AWAY FROM ACR Y. ACR X CAPT'S RPT DOES NOT BEAR THIS OUT.

SYNOPSIS: ACR X HAD LESS THAN STANDARD SEPARATION FROM ACR Y. SYSTEM ERROR.

FACILITY STATE: HI  
DISTANCE & BEARING FROM REF.: 3,,E  
MSL ALTITUDE: 20100,20100

ACCESSION NUMBER: 153054  
 DATE OF OCCURRENCE: 9008  
 REPORTED BY: FLC; ; ; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; FLC,PLT;  
 TRACON,AC; TWR,LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:NAS  
 FACILITY STATE: FO  
 FACILITY TYPE: ARPT; TRACON; TWR;  
 FACILITY IDENTIFIER: NAS; NAS; NAS;  
 AIRCRAFT TYPE: LRG; SMT;  
 ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/CLNC;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; FLC EXECUTED GAR  
 OR MAP;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: FLT WAS CLRED FOR A VIS APCH TO RWY 14 TO FOLLOW  
 AN ACR Y LGT Y. APCH ADVISED US TO SLOW TO 210 KTS UNTIL REACHING  
 PORGY INTXN AND TO CONTACT TWR AT PORGY. APCH CTL ASKED COMMUTER  
 SMT IF IT HAD OR LGT IN SIGHT. SMT REPLIED IT HAD US IN SIGHT.  
 APCH CTL THEN ISSUED A CLRNC TO FOLLOW OUR LGT TO RWY 14 AND  
 CLRED IT FOR A VIS APCH AND TO CONTACT TWR FREQ. APPROX 1100' MSL  
 (3 MI FROM END OF RWY) WE NOTICED SMT ON OUR L AND SLIGHTLY ABOVE  
 US (APPROX 200' SEP BOTH LATERAL AND VERTICAL) TURNING FROM A L  
 BASE TO FINAL. AT THAT POINT, EVASIVE ACTION WAS TAKEN BY RAPIDLY  
 DSNDING TO 800' MSL AND ACCELERATING WITH EXECUTION OF MISSED  
 APCH. AFTER CLRING TFC WE CLBED UP TO 2000' MSL AND RETURNED TO  
 FIELD WITH NO FURTHER ACTION OR INCIDENT. FINAL REMARKS, TWR DID  
 NOT ADVISE US OF TFC OR TFC CONFLICT. TWR SHOULD BE MORE VIGILANT  
 ON FOLLOW THROUGH PROGRESS OF LNDG TFC. DID NOT FOLLOW THE SMT  
 INSTRUCTIONS OF BOTH APCH CTL OR TWR.  
 SYNOPSIS: CLOSE PROX ACR-LGT GA-SMT IN ATA AT NAS.  
 REFERENCE FACILITY ID:NAS  
 FACILITY STATE: FO  
 DISTANCE & BEARING FROM REF.: 3,,NW  
 MSL ALTITUDE: 1100,1300

ACCESSION NUMBER: 159370  
 DATE OF OCCURRENCE: 9010  
 REPORTED BY: FLC; ; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TWR, LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:MCO  
 FACILITY STATE: FL  
 FACILITY TYPE: TWR;  
 FACILITY IDENTIFIER: MCO;  
 AIRCRAFT TYPE: MLG; MDT;  
 ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; LESS THAN LEGAL  
 SEPARATION;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC ABORTED TKOF;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: WE WERE CLRED FOR TKOF ON RWY 18L AT MCO. AN MDT  
 WAS LNDG ON RWY 18R AS WE RECEIVED OUR TKOF CLRNC. THE TWR CTLR  
 CLRED THE LNDG MDT TO CROSS OUR RWY JUST AS WE BROUGHT THE  
 THROTTLES UP. (F/O WAS MAKING THE TKOF.) WHEN I HEARD THE CTLR  
 CLR THE MDT TO CROSS OUR RWY, I CLRED THE THROTTLES AND STOPPED  
 THE ACFT (WHICH HAD JUST BEGUN TO MOVE). I ASKED THE TWR TO  
 VERIFY OUR TKOF CLRNC AND HE DID NOT REPLY. HE TOLD THE MDT TO  
 HOLD SHORT OF RWY 17L, AND WHEN THE MDT ACKNOWLEDGED, HE RECLRED  
 US FOR TKOF. WE THEN TOOK OFF. OBVIOUSLY A CTLR ERROR, BUT IT  
 OCCURRED TO US THAT, IF THE 2 RWYS HAD BEEN USING SEPARATE FREQS,  
 WE WOULD HAVE BEEN DENIED THE INFO WE GOT FROM THE PARTYLINE.  
 THIS IS AN IMPORTANT CONSIDERATION IF SOMEONE TRIED TO PUT  
 DATALINK INFO XFER PROCS IN OUR TWRS.  
 SYNOPSIS: ATCT LCL CTLR CLEARED AN ACFT FOR TKOF AND THEN  
 CLEARED AN ACFT TO CROSS THAT RWY. ACFT TAKING OFF ABORTED.  
 REFERENCE FACILITY ID:MCO  
 FACILITY STATE: FL

ACCESSION NUMBER: 160299  
 DATE OF OCCURRENCE: 9010  
 REPORTED BY: FLC; ; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; FLC, PIC.CAPT;  
 TWR,LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:SFO  
 FACILITY STATE: CA  
 FACILITY TYPE: ARPT; TWR;  
 FACILITY IDENTIFIER: SFO; SFO;  
 AIRCRAFT TYPE: WDB; ;  
 ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; NON ADHERENCE LEGAL  
 RQMT/FAR; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: OTHER;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: WE WERE CLRED FOR TKOF ON SFO RWY 28L AND HAD  
 REACHED ABOUT 15 KTS GNDSPD WHEN AN ACFT W OF US WAS CLRED TO  
 CROSS RWY 28L. THE PLT OF THIS ACFT IMMEDIATELY CHALLENGED THIS  
 CLRNC AND WAS TOLD TO HOLD SHORT OF RWY 28L. THIS SOLVED OUR PROB  
 AND WE CONTINUED OUR TKOF. THIS IS RPTED AS AN EXAMPLE OF THE  
 ALERTNESS AND SITUATIONAL AWARENESS ON THE PART OF THE PLT OF THE  
 OTHER ACFT AND OF THE NEED FOR CAUTION AT ALL TIMES, ESPECIALLY  
 AT TIMES OF HIGH CTLR WORKLOAD.  
 SYNOPSIS: WITH AN ACR WDB ON TKOF ROLL ATCT LCL CTLR  
 CLEARED ANOTHER ACFT TO CROSS THE ACTIVE DOWNFIELD. FLT CREW OF  
 TAXIING ACFT QUESTIONED THE CLRNC AND ATCT LCL CTLR ADVISED THEM  
 TO HOLD SHORT.  
 REFERENCE FACILITY ID:SFO  
 FACILITY STATE: CA  
 AGL ALTITUDE: 0,0

ACCESSION NUMBER: 164636  
DATE OF OCCURRENCE: 9011  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,TRNEE; FLC,ISTR; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID: BTR  
FACILITY STATE: LA  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: BTR; BTR;  
AIRCRAFT TYPE: SMT; ;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: FLC EXECUTED GAR OR MAP; CTLR INTERVENED; CTLR  
ISSUED NEW CLNC;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: I WAS WITH MY INSTR/TRNER ON A ROUTINE FLT TO  
GET CHKED OUT IN THE ACFT. WE TAXIED OUT TO RWY 31. RWY 4R WAS  
ALSO IN USE. WHEN I CALLED THE TWR FOR TKOF, HE SAID TO HOLD  
SHORT, SO I DID. ANOTHER ACFT LANDED AND TAXIED CLR. I ALSO HEARD  
HIM CLR AN ACFT TO LAND ON 4R, WHICH CROSSES 31, BUT DIDN'T PAY  
TOO MUCH ATTN. HE CLRED ME FOR TKOF WITH A LEFT TURN TO 300 DEGS.  
I TURNED ONTO THE RWY AND STARTED MY TKOF ROLL. I WAS ABOUT 50  
KTS WHEN I SAW THE ACFT ON SHORT FINAL TO 4R. THE TWR SAW HIM TOO  
AND TOLD HIM TO GO AROUND. THE CTLR MUST HAVE THOUGHT HE HAD  
ENOUGH TIME TO SEQUENCE US IN, BUT WAS MISTAKEN.

SYNOPSIS: CLOSE PROX GA SMT ON TKOF ROLL AND ACFT UNK ON  
APCH TO INTERSECTING RWY. TWR GAVE ACFT ON APCH A GO AROUND.

REFERENCE FACILITY ID: BTR  
FACILITY STATE: LA  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 171242  
DATE OF OCCURRENCE: 9102  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PIC.CAPT; TRACON,AC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:PSP  
FACILITY STATE: CA  
FACILITY TYPE: TRACON;  
FACILITY IDENTIFIER: PSP;  
AIRCRAFT TYPE: SMA; SMT;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; OTHER;  
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
ANOMALY RESOLUTION: CTLR INTERVENED;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: ENRTE VFR FROM CNO TO TUS ALT 7500' JUST E OF  
PSP VOR IN LEVEL FLT SQUAWKING DISCRETE CODE IN RADAR. LOCATION  
CONTACT CONFIRMED BY ATC ON HEARING OF SMT Y DEPARTING BERMUDA  
DUNES, I ASKED PSP APCH CTLR SPECIFICALLY TO KEEP ME ADVISED, AS  
CONVERSATION ON FREQ (126.7) IMPLIED SMT Y CLBING TOWARD ME. SMT  
Y PLT ADVISED HE HAD TFC 12 O'CLOCK X MI AT 7500', OPP DIRECTION.  
I QUERRIED CTLR "DO I HAVE TFC" 2 TIMES. HE REPLIED "TFC NO  
FACTOR". THE CTLR ADVISED SMT Y PLT URGENTLY "TURN R 20 DEG, NO  
30 DEGS TFC AVOIDANCE." SMT Y APPEARED WITH LIGHTS ON (DAYLIGHT)  
APPROX 3/4 MI APPROX 150-200' HIGHER (CTLR SAID 8000') APPROX  
50-75' TO L OF MY COURSE. HEN I TOLD CTLR THAT SEP WAS TOO CLOSE,  
HE ANGRILY RETORTED WE DON'T HAVE TO PROVIDE VFR SEP. SQUAWK  
1200, FREQ CHANGE APPROVED. TRSA IS FOR RADAR SVC. WE ALMOST LOST  
TWO ACFT, HOW MANY LIVES? DUE TO AN OBVIOUSLY IMMATURE AND POORLY  
TRNED AND SUPERVISED CTLR THAT DAY. WE DON'T SPEND BILLIONS FOR  
THAT EITHER.

SYNOPSIS: SMA VFR SAYS HAD NMAC WITH IFR SMT NEAR PSP.

SAYS POOR ATC.

REFERENCE FACILITY ID:PSP  
FACILITY STATE: CA  
DISTANCE & BEARING FROM REF.: 7,70  
MSL ALTITUDE: 7500,8000

ACCESSION NUMBER: 181950  
 DATE OF OCCURRENCE: 9106  
 REPORTED BY: FLC; ; FLC; ; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; FLC, PIC.CAPT;  
 TWR,LC; TWR,LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:MIA  
 FACILITY STATE: FL  
 FACILITY TYPE: TWR;  
 FACILITY IDENTIFIER: MIA;  
 AIRCRAFT TYPE: LRG; LTT;  
 ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; NON ADHERENCE LEGAL  
 RQMT/PUBLISHED PROC;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: ACFT EXITED ADVERSE ENVIRONMENT; OTHER; CTLR  
 ISSUED NEW CLNC;  
 ANOMALY CONSEQUENCES: FAA INVESTIGATORY FOLLOW-UP; FLC/ATC REVIEW;  
 SITUATION REPORT SUBJECTS: PHYSICAL FACILITY/ATC; PROC OR  
 POLICY/ATC FACILITY; PROC OR POLICY/FAA;  
 NARRATIVE: ACR X CLRED FOR TKOF RWY 9L MIA. I HEARD ACR Y  
 MAKE SOME COMMENT RE: RWY 9L AND LOOKED UP TO SEE HIM ON SHORT  
 FINAL 9L. I STOPPED SHORT OF 9L AND TWR ASKED ACR Y TO LAND RWY  
 12. HE TRANSITIONED FROM ABOUT 1/2 MI FINAL TO RWY 12. TWR SAID  
 WE HAD BEEN CLRED INTO POS RWY 12. ALL 3 OF OUR PLT CREW MEMBERS  
 WERE POSITIVE IT WAS 9L UPON SUBSEQUENT INVESTIGATION. MIA TWR  
 HAD MADE THE ERROR AND HAD ALMOST CAUSED THE ACCIDENT. THE CTLR  
 WAS A TRNEE AND THE SUPVR MUST NOT HAVE BEEN CLOSELY SUPERVISING.  
 THIS IS THE SECOND INCIDENT IN MIA IN LESS THAN 7 DAYS. I'VE  
 NOTICED A DEFINITE DECLINE IN CTLR COMPETENCY OVER THE PAST FEW  
 YRS. THE QUALITY OF PERSONNEL DOES NOT SEEM TO MEET PAST  
 STANDARDS. SUPPLEMENTAL INFO FROM ACN 182629: WE WERE TOLD BY TWR  
 TO TAXI INTO POS ON RWY 9L, THE F/O READ BACK, "ROGER, POS AND  
 HOLD RWY 9L" JUST AFTER XING THE HOLD SHORT, THE CAPT NOTICED A  
 SMALL TWIN LINED UP TO LAND ON 9L AT ABOUT 1/2 MI.  
 SIMULTANEOUSLY, ACR Y CALLED TWR TO ASK WHAT WAS GOING ON. THE  
 CAPT STOPPED OUR ACFT JUST SHORT OF THE RWY. THE TWR CTLR THEN  
 INSTRUCTED THE ACR Y TO LAND ON RWY 12 AND THEN ACCUSED US OF  
 GOING TO THE WRONG RWY.  
 SYNOPSIS: CTLR TRAINING IN PROGRESS LCL CTLR TAXIED ACR X  
 ONTO RWY IN FRONT OF ACR Y LNDG.  
 REFERENCE FACILITY ID:MIA  
 FACILITY STATE: FL  
 DISTANCE & BEARING FROM REF.: 0  
 AGL ALTITUDE: 0,0

ACCESSION NUMBER: 184688  
 DATE OF OCCURRENCE: 9107  
 REPORTED BY: FLC; ; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TRACON,AC;  
 FLIGHT CONDITIONS: MXD  
 REFERENCE FACILITY ID:SMO  
 FACILITY STATE: CA  
 FACILITY TYPE: ARPT; TRACON;  
 FACILITY IDENTIFIER: LAX; LAX;  
 AIRCRAFT TYPE: MLG; MLG;  
 ANOMALY DESCRIPTIONS: NO SPECIFIC ANOMALY OCCURRED;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: CTLR INTERVENED; NOT RESOLVED/UNABLE;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: DURING VERY BUSY PERIOD OF IFR ARRS APCH CTL  
 ISSUED A CLRNC TO AN ACFT (UNKNOWN CALL SIGN) TO 'DSND TO 2500  
 FT'. THE OTHER AIRPLANE READ BACK 'CLRED TO 1500 FT'. APCH CTLR  
 MISSED THE ERROR AS HE WAS OVERLOADED. I ATTEMPTED TO TELL APCH  
 CTLR BUT TRANSMISSION WAS BLOCKED BY OTHER TRANSMISSIONS. I WAS  
 NOT SURE WHO THE WRONG CLRNC WAS FOR AND WRONGFULLY ASSUMED THAT  
 MODE C READOUTS WOULD KEEP EVERYONE OK. I KNEW THERE WAS CEILING  
 OF AROUND 1000 FT, AND RATIONALIZED THAT A TRAGEDY WOULD NOT  
 OCCUR. HOWEVER, THE CTLR DID NOT NOTICE THE ALT ERROR UNTIL 1500  
 FT, WHEN THE OFFENDING ACR WAS TOLD TO GO BACK TO 2500 FT. I  
 LEARNED 2 THINGS. I SHOULD HAVE INSISTED ON RELAYING THE ERROR TO  
 APCH, EVEN IF IT WAS ME WHO MISUNDERSTOOD. ALSO THE ACR DIDN'T  
 READ BACK CORRECTLY, TERMINOLOGY WISE. ('1500' APCH WOULD'VE  
 PROBABLY NOTICED.)  
 SYNOPSIS: ATTEMPTED TO ADVISE CTLR ACFT HAD COPIED CLRED  
 ALT WRONG.  
 REFERENCE FACILITY ID:SMO  
 FACILITY STATE: CA  
 MSL ALTITUDE: 7000,7000

ACCESSION NUMBER: 185329  
DATE OF OCCURRENCE: 9108  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; TWR,LC; FLC,PLT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:IPT  
FACILITY STATE: PA  
FACILITY TYPE: TWR;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;  
ANOMALY DETECTOR: COCKPIT;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;

NARRATIVE: AN SMA A FLOATPLANE, WAS INBOUND TO THE IPT VOR AT 3400 MSL, COURSE 010 MAGNETIC. SMA A CALLED THE TWR AT IPT 8.1 DME FROM THE VOR, INDICATING THE INTENTION TO CONTINUE INBOUND TO THE VOR AND DEPART NE TO N27. THE IPT TWR RESPONDED IN THE AFFIRMATIVE, REQUESTING A RPT WHEN N OF THE RWY CENTERLINE IF VISIBLE. IMMEDIATELY THEREAFTER, THE IPT TWR CLRED AN SMA B TO FLY A LOC APCH INTO IPT. THE SMA B RPTED 4000 MSL, DSNDING. UPON HEARING THE SMA B RPTING ITS POS AT 'PICTURE ROCKS', A TOWN MARKED ON THE VFR SECTIONAL, SMA A QUERIED THE SMA B DIRECTLY FOR ALT. THE SMA B REPLIED 3700 DSNDING. SMA A IMMEDIATELY BEGAN CIRCLING TO HOLD A POS S OF THE LOC UNTIL THE SMA B HAD PASSED, NOTIFYING THE TWR OF 'EVASIVE ACTION'. AFTER TURNING APPROX 110 DEG TO THE R, SMA A OBSERVED THE SMA B PASSING ABOUT 100 FT BELOW AND 300 FT N. SMA A THEN RESUMED ITS PROGRESS TOWARD THE VOR AND WAS NOTIFIED BY THE IPT TWR THAT THERE WAS NO TFC TO RPT. THE MAIN CONTRIBUTING FACTOR WAS THE ACTION OF THE IPT TWR CLRING 2 ACFT WITHIN ITS CTL ONTO A COLLISION COURSE. SMA A WAS CLRED TO CROSS THE LOC AT 3400 FT AT THE SAME TIME THE SMA B WAS CLRED TO CONDUCT A LOC APCH STARTING AT 4000 FT. THE RPTR FEELS THAT THE SMA B LOCATION WAS AS MUCH AS A MI S OF THE LOC APCH, NEGATING THE EFFECTIVENESS OF HIS HOLDING ACTION. THE DISCUSSION OF THE 'PICTURE ROCKS' INBOUND LOC WAYPOINT, WHICH WAS ON THE VFR SECTIONAL, ALERTED SMA A TO THE IMMINENT POTENTIAL FOR A COLLISION. EVASIVE ACTION BY SMA A PREVENTED A VERY NEAR MISS OR A POSSIBLE COLLISION. THE HUMAN PERFORMANCE OF THE IPT ATA CTLR FAILED TO ENHANCE THE ACFT SEPARATION WITHIN THE BOUNDS OF THE ATA. THE RPTR FEELS THAT THE TWR CTLR AT IPT DID NOT HAVE A PICTURE OF THE TFC WITHIN THE ATA. THE CTLR'S JUDGEMENT AND SUBSEQUENT INACTION, CREATED A VERY HAZARDOUS CIRCUMSTANCE. I FEEL THAT THE CTLR SHOULD HAVE DIRECTED SOME ACTION TO CREATE POSITIVE VERT OR HORIZ SEPARATION RATHER THAN SIMPLY LEAVING IT UP TO THE AIRCREWS INVOLVES TO PROVIDE SEPARATION VIA SEE-AND-AVOID. I RECOGNIZE THAT SEE-AND-AVOID IS A CONTINUING AIRCREW RESPONSIBILITY, BUT WHEN UNDER POSITIVE CTL IN AN ATA, THE CTLR IS EXPECTED TO HELP BY POSITIVE ACTIONS ENHANCING SEPARATION.

SYNOPSIS: SMA CLRED TO VOR AS SECOND ACFT CLRED FOR ILS APCH. NMAC.

REFERENCE FACILITY ID:IPT  
FACILITY STATE: PA  
DISTANCE & BEARING FROM REF.: 8,,SO  
MSL ALTITUDE: 3300,3400

ACCESSION NUMBER: 202138  
DATE OF OCCURRENCE: 9202  
REPORTED BY: FLC; ; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TRACON,DC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SLC  
FACILITY STATE: UT  
FACILITY TYPE: ARPT; TRACON;  
FACILITY IDENTIFIER: SLC; SLC;  
AIRCRAFT TYPE: LRG; LRG;  
ANOMALY DESCRIPTIONS: CONTROLLED FLT TOWARD TERRAIN; NON ADHERENCE  
LEGAL RQMT/OTHER; OTHER;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: CTLR INTERVENED; CTLR ISSUED NEW CLNC; ACFT  
EXITED ADVERSE ENVIRONMENT;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
NARRATIVE:

WE WERE AN LGT X, DEPARTING SLC TO DENVER VIA  
DIRECT SLC VOR, J-56 DEN. COMPANY LGT Z DEPARTED BEFORE US.  
COMPANY LGT Y DEPARTED AFTER US. EACH OF US HAD THE SAME RTE --  
SLC, J-56 DEN, AND ALL TOOK OFF FROM RWY 16R. AFTER TKOF AND  
CLRED TO 8000 FT, WE WERE TURNED TO 280 DEGS AND TO MAINTAIN  
VISUAL SEPARATION ON LGT Z. SWITCHED TO SLC DEP WE WERE  
INSTRUCTED TO CLB TO 9000 FT AND FLY 300 DEGS. MEANWHILE, LGT Z  
WAS CLRED TO THE SLC VOR FLT PLAN RTE AND CLRED TO 16000 FT. WE  
WERE TURNED TO 330 DEGS AND TOLD TO STAY AT 9000 FT DUE TO LGT Z  
XING OVERHEAD. MEANWHILE LGT Y CHKED IN AND RECEIVED SIMILAR  
VECTORS. WE WERE CLRED DIRECT SLC VOR FLT PLAN RTE WITH NO ALT  
CHANGE. LGT Y WAS CLRED TO 16000 FT, WHICH THEY ACKNOWLEDGED. WE  
COULD SEE THE ARRIVING ACFT AT 9000 FT IN THE 16R TFC PATTERN AND  
SAW A POTENTIAL CONFLICT BUT WE WERE STILL 5-6 MI FROM THE  
NEAREST ACFT. OUR TCASII WAS WORKING OK AND SHOWED THE OTHER  
ACFT. SLC DEP CALLED (SORT OF FRANTICALLY) AND TOLD US TO  
EXPEDITE OUT OF 10000 FT. WE TOLD HIM WE HAD NEVER BEEN CLRED OUT  
OF 9000 FT. HE SAID HE HAD CLRED US TO 16000 FT AND MAYBE LGT Y  
HAD ANSWERED. LGT Y THEN STATED THERE WAS ONLY ONE 16000 CLB AND  
IT HAD BEEN FOR LGT Y. WE CONCURRED. WE IMMEDIATELY CLBED OUT OF  
9000 FT TO 16000 FT. THERE WERE NO NEAR MISSES, JUST CTLR  
CONFUSION WITH 3 CONSECUTIVE DEPS WITH SAME RTING AND 2 VERY  
SIMILAR CALL SIGNS. AFTER IT WAS OVER THE CTLR ADMITTED HE WAS  
CONFUSED WITH THE SIMILAR CALL SIGNS. AUTOMATION INFO: I TURNED  
THE AUTOPLT ON AFTER THE INITIAL LEVEL OFF AT 8000 FT (BEFORE THE  
CONFUSION) SO THAT WE WOULD HAVE BETTER SITUATIONAL AWARENESS.  
UNFORTUNATELY THE CTLR DID NOT HAVE THE SAME CAPABILITY.

SYNOPSIS: POTENTIAL CONFLICT AND POSSIBLE CFTT IN AN  
ALTDEV.

REFERENCE FACILITY ID:SLC  
FACILITY STATE: UT  
DISTANCE & BEARING FROM REF.: 14,,NW  
MSL ALTITUDE: 9000,16000

ACCESSION NUMBER: 202475  
 DATE OF OCCURRENCE: 9202  
 REPORTED BY: FLC; ; FLC; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; FLC, PIC.CAPT;  
 TWR,LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:LAS  
 FACILITY STATE: NV  
 FACILITY TYPE: TWR; ARPT;  
 FACILITY IDENTIFIER: LAS; LAS;  
 AIRCRAFT TYPE: LRG; ;  
 ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; OTHER; NON ADHERENCE  
 LEGAL RQMT/CLNC;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC ABORTED TKOF;  
 ANOMALY CONSEQUENCES: NONE;  
 SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;  
 NARRATIVE: APCHING RWY 25R, TWR CLRED US (ACR AB XYZ) FOR  
 TKOF. WE BEGAN OUR TKOF ROLL WHEN WE HEARD THE TWR ADVISE ACR CB  
 XYZ TO HOLD SHORT OF 25R AFTER LNDG. HE WAS LNDG ON 25L. THE FO  
 WAS MAKING THE TKOF AND BECAUSE OF THE COMMON FLT NUMBER HE  
 HESITATED VERY BRIEFLY ADVANCING PWR LEVERS UNTIL I MENTIONED THE  
 TRANSMISSION WAS NOT FOR US. AS WE WERE ACCELERATING, I NOTICED  
 CB XYZ TURNING OFF 25L AT A FAIRLY RAPID SPD AND THOUGHT HE MIGHT  
 NOT BE STOPPING SHORT OF OUR RWY. I WATCHED HIM AND AT ABOUT 115  
 KTS IT WAS CLR TO ME CB XYZ WASN'T STOPPING, SO I ABORTED THE  
 TKOF. AT ABOUT THE SAME MOMENT CB XYZ MADE AN ABRUPT STOP WITH  
 HIS NOSE SLIGHTLY EXTENDING ONTO RWY 25R. WE STOPPED SHORT OF HIS  
 POS AND WITHOUT INCIDENT. CB XYZ COMMENTED TO TWR THAT THEY  
 THOUGHT THEY HAD BEEN CLRED TO CROSS RWY 25R. MY DISCUSSION WITH  
 THE TWR DID NOT INDICATE ANY MISTAKE OR MISUNDERSTANDING ON OUR  
 PART, HOWEVER, THE COMMON FLT NUMBER CERTAINLY CAUSED US SOME  
 HESITATION BY WAY OF POSSIBLE MISUNDERSTANDING. THIS CERTAINLY  
 COULD HAVE BEEN RESPONSIBLE FOR CB XYZ MISTAKE. THERE IS  
 SIGNIFICANT POTENTIAL FOR MISUNDERSTANDINGS AND ERRORS WITH  
 COMMON OR SIMILAR FLT NUMBERS ON FREQ. SOME TYPE OF MONITORING  
 AND CONTACT WITH THE AFFECTED AIR CARRIERS INVOLVED SHOULD BE  
 DONE BY THE ATC FACILITIES.  
 SYNOPSIS: ACR ON TKOF ROLL SEES ACR WITH IDENTICAL CALL  
 SIGN FAIL TO HOLD SHORT OF RWY. TKOF ABORTED.  
 REFERENCE FACILITY ID:LAS  
 FACILITY STATE: NV  
 DISTANCE & BEARING FROM REF.: 0  
 AGL ALTITUDE: 0,0

ACCESSION NUMBER: 207989  
DATE OF OCCURRENCE: 9204  
REPORTED BY: FLC; FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; ARTCC,RDR; TRACON, AC;  
FLIGHT CONDITIONS: MXD  
REFERENCE FACILITY ID:RIC  
FACILITY STATE: VA  
FACILITY TYPE: ARTCC; ARPT;  
FACILITY IDENTIFIER: ZDC; EWR;  
AIRCRAFT TYPE: LRG;  
ANOMALY DESCRIPTIONS: ACFT EQUIPMENT PROBLEM/CRITICAL; NON ADHERENCE  
LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: CTLR INTERVENED;  
ANOMALY CONSEQUENCES: OTHER;  
SITUATION REPORT SUBJECTS: ACFT EQUIPMENT;

NARRATIVE: WHILE ENRTE ON VECTORS FROM ZDC WE WERE CALLED FROM COMPANY RADIO TO CONTACT ZDC. THE FREQ GIVEN US WAS THE FREQ SET ON OUR RADIO. WE RECHANNELED THE RADIO AND ESTABLISHED CONTACT. WE WERE TOLD THEY HAD BEEN CALLING FOR 100 NM. WE NEVER HEARD A CALL! ON APCH WITH EWR APCH AGAIN ON VECTORS, WE HEARD THE MALE CTLR TURN INTO A FEMALE. THINK THERE HAD BEEN A CTLR CHANGE! WE CONTINUED FOR SOME TIME LISTENING TO CONSTANT TFC CTILING. WE HAD CROSSED THE LOC AND WERE 15 OR SO MI THROUGH THE LOC WHEN WE ASKED 'WHAT'S THE PLAN FOR US?' WE WERE MET WITH WHO ARE YOU, WHERE ARE YOU, YOU ARE ON THE WRONG FREQ! AGAIN LOST COM. WE RE-ESTABLISHED COM WITH EWR APCH AND WERE VECTORED UNEVENTFULLY. WE FINALLY DISCOVERED THAT OUR RADIO HAD BEEN CHANGING FREQS WITHOUT BEING TOUCHED. THE FIRST TIME THE CORRECT FREQ IN THE WINDOW, THE SECOND THE FREQ IN THE WINDOW WAS DIFFERENT THAN THAT SELECTED ORIGINALLY AND IMMEDIATELY CHANGED 7 DIGITS WHEN BARELY TOUCHED. AND A THIRD TIME WHEN GND WAS PRE-SELECTED PRIOR TO LNDG AND HAD CHANGED FROM 121.8 TO 131.8. THESE WERE DUAL HEAL TYPE RADIO. SUPPLEMENTAL INFO FROM ACN 207782. WE WERE TURNED TO A HDG OFF THE AIRWAY FOR TFC. AFTER APPROX 5 MIN WE GET A SELCAL AND ARE TOLD TO CONTACT WASHINGTON CTR ON 2 DIFFERENT FREQS, ONE BY ATLANTA RADIO AND ONE BY ANOTHER COMPANY FLT. WE WENT BACK TO THE PREVIOUS FREQ AND ASKED THE CTLR FOR A CORRECT FREQ AND HE SENT US BACK TO THE ONE WE WERE JUST ON. THE RADIO HAD AUTOMATICALLY CHANNELIZED WITHOUT OUR KNOWING IT AND NO CHANGE OF FREQ SHOWING ON THE CTL HEAD. TO OUR KNOWLEDGE THERE HAD BEEN NO TFC CONFLICT. THIS SITUATION WAS VERY INSIDIOUS BUT BETTER SITUATIONAL AWARENESS MIGHT HAVE RESOLVED THE PROBLEM SOONER. ON DIGITAL RADIO CTL HEADS BE AWARE THEY RECHANNELIZE WITH NO COCKPIT INDICATIONS.

SYNOPSIS: COM RADIO FREQS IN A HIGH TECH LGT CHANGE SPONTANEOUSLY CAUSING LOSS OF RADIO CONTACT WITH ATC. SOMETIMES THE FREQ DISPLAY CHANGES IN CONJUNCTION WITH THE FREQ CHANGE AND SOMETIMES THE FREQ DISPLAY DOES NOT CHANGE AS THE FREQ CHANGES.

REFERENCE FACILITY ID:RIC  
FACILITY STATE: VA  
DISTANCE & BEARING FROM REF.: 80,240  
MSL ALTITUDE: 35000,35000

ACCESSION NUMBER: 217638  
DATE OF OCCURRENCE: 9208  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TWR, LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SFO  
FACILITY STATE: CA  
FACILITY TYPE: ARPT; TWR; TWR;  
FACILITY IDENTIFIER: SFO; SFO; SFO;  
AIRCRAFT TYPE: LTT; MLG;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; LESS THAN LEGAL  
SEPARATION; NON ADHERENCE LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY; PROC OR  
POLICY/COMPANY;

NARRATIVE: ON AUG/SUN/92, FLT FROM SMF TO SFO WAS CLRED TO  
LAND ON RWY 28R. DURING DECELERATION, TWR CLRED US TO CROSS RWY  
28L AND CONTACT GND CTL AFTER XING. WE EXITED RWY 28R ON TAXIWAY  
'E' AND BEFORE ENTERING RWY 28L WHILE STILL INBTWN OF RWYS I  
HEARD TWR CLR AN ACFT FOR TKOF ON RWY 28L. MY REACTION WAS TO  
STOP MY ACFT BEFORE ENTERING THE RWY 28L BOUNDARY WHICH WE  
MANAGED TO DO SO. I LOOKED TO MY L AND SAW AN ACFT AT THE APCH  
END OF RWY 28L AND AT THAT POINT I DECIDED TO POSTPONE MY RWY  
XING UNTIL AFTER DEP OF THAT ACFT AND FURTHER CLRNC BY TWR. A FEW  
SECONDS LATER TWR CTLR ONCE AGAIN CLRED US FOR AN IMMEDIATE XING  
OF RWY 28L AND WITHOUT DELAY RETURNED TO DEPARTING ACFT AND  
ORDERED HIM TO ABORT HIS TKOF. AT THIS POINT, BASED ON MY  
JUDGEMENT OF HIS ROLLING SPD AND ESTIMATED OVER 6000 FT OF  
DISTANCE BTWN US, AND ASSUMING HE IS ON THE TKOF ABORTION STAGE,  
I EXECUTED AN EXPEDITIOUS XING OF RWY 28L. DURING XING I  
MAINTAINED A VISUAL CONTACT WITH THE TFC AND ENSURING THE SAFETY  
OF MY ACFT FROM THE TAKING OFF TFC WHO FAILED TO RESPOND TO  
REPEATED TKOF CANCELLATION FROM TWR. AT NO TIME DURING THIS  
ORDEAL WAS SAFETY OF MY ACFT OR PAX COMPROMISED. MY SUGGESTION  
WOULD BE MORE CAREFUL CTLRS AND MORE SITUATION AWARENESS IN TWR.  
ALSO, ON THE PART OF THE OTHER INVOLVED ACFT. TO LISTEN CLOSER TO  
ATC.

SYNOPSIS: ACR LTT PIC INDUCES A DEPARTING ACFT INTO AN  
ABORT SITUATION WHEN HE FAILS TO COMPLY WITH TWR'S CLRNC TO CROSS  
RWY 28L.

REFERENCE FACILITY ID:SFO  
FACILITY STATE: CA  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 235833  
 DATE OF OCCURRENCE: 9303  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; TWR,LC; FLC, PIC.CAPT;  
 FLIGHT CONDITIONS: MXD  
 REFERENCE FACILITY ID:ORD  
 FACILITY STATE: IL  
 FACILITY TYPE: TWR; ARPT;  
 FACILITY IDENTIFIER: ORD; ORD;  
 AIRCRAFT TYPE: MLG; WDB;  
 ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; OTHER; NON  
 ADHERENCE LEGAL RQMT/CLNC;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; FLC EXECUTED GAR  
 OR MAP;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: INSIDE MARKER ON ILS RWY 22R ORD I HAD 1 ACFT  
 APPROX 5 MI IN FRONT. AFTER HE LANDED, TWR CLRED FOREIGN ACR TO  
 TKOF ON RWY 32R, THE CTLR NOTING THAT FOREIGN ACR WAS SLOW TO  
 RESPOND ISSUED AN EXPEDITE ORDER. STILL NOTING FOREIGN ACR WAS  
 NOT ACTING FAST ENOUGH HE TOLD FOREIGN ACR TO CANCEL TKOF CLRNC.  
 FOREIGN ACR DID NOT RESPOND. THE CTLR ISSUED 3 MORE ORDERS TO  
 ABORT AND FOREIGN ACR WOULD NOT ACKNOWLEDGE OR ABORT. AT 1000 FT  
 AGL WE ELECTED TO GAR. THE GAR WAS UNEVENTFUL. IF WE WOULD NOT  
 HAVE GONE AROUND, WE WOULD HAVE COLLIDED WITH FOREIGN ACR JUST AS  
 HE ROTATED FOR TKOF.  
 SYNOPSIS: MLG FLC EXECUTES A GAR DUE TO FOREIGN CARRIER  
 NOT RESPONDING TO CTLR INSTRUCTIONS TO ABORT ON INTERSECTING RWY.  
 REFERENCE FACILITY ID:ORD  
 FACILITY STATE: IL  
 DISTANCE & BEARING FROM REF.: 8,,NE  
 MSL ALTITUDE: 1000,1000

**INSTRUCTIONAL PLI ELEMENTS: Correct Transmission, Incorrect Action**

ACCESSION NUMBER: 102994  
DATE OF OCCURRENCE: 8901  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PLT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:GGG  
FACILITY STATE: TX  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: GGG; GGG;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; RWY TRANSGRESS/OTHER;  
NON ADHERENCE LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: CTLR INTERVENED; CTLR ISSUED NEW CLNC; FLC  
EXECUTED GAR OR MAP;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: TAXI INSTRUCTIONS WERE AS FOLLOWS: "CLRED TO RWY  
35." I REPEATED IT. AT THIS POINT I ASSUMED I WAS CLR TO THE END  
OF 35--MY FIRST MISTAKE. AS I STARTED I HEARD GND CTLR GIVING  
INSTRUCTIONS TO AN SMA Y IN THE PATTERN. I CAME TO ONE INTXN AND  
SAW RWY 31-13 AND PASSED IT, THEN WENT TO THE NEXT INTXN. AS I  
APCHED I HEARD ON THE GND FREQ THE SAME CTLR TELL THE SMA Y THAT  
HE WAS CLRED FOR TOUCH AND GO, BUT NOT TO CROSS A CERTAIN POINT,  
WHICH I MISSED. BUT BY HEARING THIS, IT CONFIRMED MY BELIEF THAT  
I COULD CROSS 35. THERE WERE MORE XMISSIONS FOR AWHILE. I SAW THE  
SMA Y ON FINAL AND HE LOOKED PRETTY FAR OUT WHICH AGAIN MADE ME  
THINK THAT THE CTLR MEANT FOR ME TO GO ACROSS. I STARTED ON THE  
RWY, STILL NO XMISSION. HALF WAY ACROSS STILL NO XMISSION. 2/3 OF  
THE WAY ACROSS GND CTLR TOLD SMA Y TO GO AROUND. I WAS ALMOST OFF  
35 AND THE SMA Y WASN'T QUITE TO THE THRESHOLD. THEN GND TOLD ME  
I JUST CROSSED THE ACTIVE W/O PERMISSION. TECHNICALLY I JUST  
BUSTED FAR 91.87 HOTEL. I REALIZE THAT I ASSUMED TOO MUCH DURING  
TAXI, BUT FEEL THAT ONE CTLR SHOULDN'T HANDLE GND AND TWR OPS,  
ESPECIALLY AT AN ARPT WITH SEVERAL INTERSECTING RWYS. WHY DID THE  
CTLR WAIT SO LONG TO CALL MY MISTAKE IF I WAS SUCH A DANGER. ARE  
NO GND CTLRS SUPPOSED TO MONITOR GND TFC? I WAS RAISED AT A ONE  
RWY, UNCONTROLLED FIELD AND NOW OPERATE OUT OF A ONE RWY, CTLED  
FIELD. PERHAPS BETTER CONTROLLED FIELD TRNING WOULD HAVE HELPED  
ME. I FEEL THAT ATC AND PLTS SHOULD WORK AS A TEAM AND LOOK OUT  
FOR EACH OTHER. IF ONE SEES A MISTAKE DEVELOPING, CALL IT TO ATTN  
ASAP--DON'T WAIT TILL ALREADY HAPPENED.  
SYNOPSIS: GA-SMA UNAUTH RWY CROSSING CAUSES SECOND GA-SMA  
TO GO AROUND.  
REFERENCE FACILITY ID:GGG  
FACILITY STATE: TX  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 103001  
DATE OF OCCURRENCE: 8901  
REPORTED BY: FLC; FLC; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:MDW  
FACILITY STATE: IL  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: MDW; MDW;  
AIRCRAFT TYPE: SMT;  
ANOMALY DESCRIPTIONS: NON ADHERENCE LEGAL RQMT/CLNC; NON ADHERENCE  
LEGAL RQMT/FAR;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: NOT RESOLVED/ANOMALY ACCEPTED;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
NARRATIVE: 2 COMMUTER SMT'S WERE HOLDING SHORT ON PARALLEL

RWYS. BOTH WERE #1 FOR TKOF ON THEIR ASSIGNED RWYS. THE 2  
AIRPLANES HAD SIMILAR CALL SIGNS (COMPANY AHEF HOLDING SHORT OF  
22R, THIS WAS THE AIRPLANE THAT I WAS IN, AND COMPANY AHHF  
HOLDING SHORT OF 22L). AHHF WAS GIVEN A TKOF CLRNC ON 22L AND I  
THOUGHT IT WAS OUR AIRPLANE AHEF THAT WAS CLRED FOR TKOF ON 22R.  
I READ BACK THE TKOF CLRNC VERBATIM, "CLRED FOT TKOF ON 22R, TURN  
RIGHT TO 090 DEGS COMPANY AHEF." THERE WAS NO ACKNOWLEDGEMENT  
FROM THE TWR, SO WE TOOK OFF AND AHHF TOOK OFF ON 22L ABOUT 1 MIN  
BEFORE US. THERE WAS NO CONFLICT OR EVASIVE ACTION NEEDED, BUT IN  
ANY CASE WE DID TKOF W/O A CLRNC. MY CAPT HELPED CAUSE THE PROB  
BECAUSE DURING THE CRITICAL PHASE OF FLT, WHEN THERE SHOULD HAVE  
BEEN NO TALKING IN THE COCKPIT EXCEPT CHKLIST ITEMS WHILE WE WERE  
HOLDING SHORT, HE WAS TEACHING ME AND QUIZZING ME SINCE I'M A NEW  
F/O . I THINK A GOOD SOLUTION TO THE PROB WOULD BE TO MORE  
STRICTLY ENFORCE THE CRITICAL PHASE OF FLT QUIET PERIOD AND ONLY  
TALK ABOUT CHKLIST ITEMS AND CREW DUTIES AND ALSO TRY NOT TO HAVE  
FLTS WITH SIMILAR CALL SIGNS DEPART AT THE SAME TIME.  
SUPPLEMENTAL INFO FROM ACN 103135: TWR SUPVR ASKED ME TO CALL TWR  
AT DEST. I CALLED. HE SAID HE WAS WORKING WITH LCL CTLR AT THE  
TIME OF OUR DEP AND HAD TO CALL O'HARE TO COORDINATE A HDOF AND  
AFTER FINISHING WITH O'HARE SAW US DEPART ON 22R. I WAS ANSWERING  
A QUESTION FROM MY F/O IN RESPECT TO TKOF PROC.

SYNOPSIS: COMMUTER SMA UNAUTH TKOF IN RESPONSE TO WRONG  
CALL SIGN WITH SIMILAR A/N, SAME A/N.

REFERENCE FACILITY ID:MDW  
FACILITY STATE: IL  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 103105  
 DATE OF OCCURRENCE: 8901  
 REPORTED BY: FLC; ;  
 PERSONS FUNCTIONS: FLC,PLT; TWR,LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:LGB  
 FACILITY STATE: CA  
 FACILITY TYPE: TWR;  
 FACILITY IDENTIFIER: LGB;  
 AIRCRAFT TYPE: SMA;  
 ANOMALY DESCRIPTIONS: RWY TRANSGRESS/OTHER; OTHER; NON ADHERENCE LEGAL  
 RQMT/CLNC; NON ADHERENCE LEGAL RQMT/FAR;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC BECAME REORIENTED; FLC RETURNED ACFT TO  
 ORIGINAL CLNC OR INTENDED COURSE;  
 SITUATION REPORT SUBJECTS: AN INTXN NAME OR OTHER NAME;  
 NARRATIVE: CONTACTED LGB W FOR LNDG AND INFORMED ON INITIAL  
 CONTACT THAT PLT WAS UNFAMILIAR. WAS INSTRUCTED TO ENTER RIGHT  
 DOWNWIND FOR 25R. LANDED AND DURING ROLLOUT WAS INSTRUCTED, "LEFT  
 NEXT TXWY," BUT AT THIS POINT WAS UNABLE TO POSITIVELY IDENT THE  
 NEXT OPENING AS A TXWY (IT WAS VERY NARROW AND HAD NO YELLOW  
 STRIPE LEADING TO IT FROM THE RWY CENTERLINE). IMMEDIATELY AFTER  
 RECEIVING THIS INSTRUCTION, ANOTHER ACFT (WHICH WAS ALREADY  
 HOLDING IN POS ON 25R) WAS CLRED FOR TKOF 25R. HEARING THIS  
 CAUSED ME TO PANIC. I WAS AFRAID OF CROSSING RWY 30 WHICH I HAD  
 BEEN GIVEN LNDG INSTRUCTIONS TO HOLD SHORT OF, BUT WITH THE PLANE  
 BEHIND ME CLRED FOR TKOF I DIDN'T HAVE ENOUGH TIME TO VERIFY MY  
 POS WITH THE TWR AND SO TOOK THE NEXT LEFT TO CLR THE RWY, WHICH  
 TURNED OUT TO BE THE APCH END OF 16R. I REALIZED THIS AS SOON AS  
 I TURNED AND IMMEDIATELY INFORMED THE TWR. I STAYED ALL THE WAY  
 TO THE LEFT OT 16L, ALMOST ON THE GRASS. THE TWR SAID, "TURN  
 LEFT! TAXI ACROSS THE GRASS! ACROSS THE GRASS!" I DID TURN LEFT  
 AND AT NEAR FULL THROTTLE WAS IMMEDIATELY ONTO TXWY KILO, BUT  
 PARTIALLY ENTERED RWY 30 IN THE PROCESS. THIS SITUATION OCCURRED  
 PARTLY DUE TO MY LACK OF EXPERIENCE AS A PLT, AND LIMITED  
 EXPERIENCE WITH UNFAMILIAR ARPTS. CONTRIBUTING FACTORS ALSO  
 INCLUDE: NON UNIFORM TXWY MARKINGS AND DIMENSIONS AT DIFFERENT  
 ARPTS; NON UNIFORM TERMINOLOGY--SOMETIMES IT'S "LEFT THIS TXWY,"  
 SOMETIMES IT'S "LEFT NEXT TXWY," WHICH IF YOU ARE VERY CLOSE TO A  
 TXWY (AS I WAS) MIGHT BE CONSTRUED AS THE TXWY AFTER THE ONE YOU  
 HAVE ALMOST PASSED; PLANES BEING CLRED ONTO THE RWY DURING  
 ANOTHER ACFT'S FINAL APCH AND PLANES BEING CLRED FOR TKOF BEFORE  
 THE PLANE WHICH LANDED PREVIOUSLY IS ACTUALLY OFF THE RWY (AS IN  
 THIS CASE); AND CTLRS SHOULD TAKE HEED WHEN A PLT LNDG AT AN ARPT  
 AS COMPLEX AS LGB INFORMS THAT THEY ARE UNFAMILIAR.  
 SYNOPSIS: GA SMA AT UNFAMILIAR ARPT MISSES ASSIGNED TXWY  
 AND TRANSGRESSES INTERSECTING RWY. ATCT LCL CTLR OPERATIONAL  
 DEVIATION, CLEARING ACFT FOR TKOF WHEN ANOTHER ACFT STILL ON RWY.  
 REFERENCE FACILITY ID:LGB  
 FACILITY STATE: CA  
 AGL ALTITUDE: 0,0

ACCESSION NUMBER: 109950  
DATE OF OCCURRENCE: 8904  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT; TRACON,AC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:MLI  
FACILITY STATE: IL  
FACILITY TYPE: TRACON;  
FACILITY IDENTIFIER: MLI;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; NON ADHERENCE  
LEGAL RQMT/CLNC; NON ADHERENCE LEGAL RQMT/FAR;  
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;  
ANOMALY CONSEQUENCES: OTHER;

NARRATIVE: I HAD 2 JUMPERS GOING OUT AT 7500' AGL. WHILE HEADED APPROX SBND 2 NM N OF THOMPSON FIELD (PVT) QUAD CITY APCH ADVISED ME OF AN INBND SMA AT A DIRECTION E OF ME, SAME ALT. I TOLD THE CTLR I WOULD BE LOOKING FOR THE TFC; I SHOULD POINT OUT THAT ON INITIAL CONTACT WITH QUAD CITY APCH. I WAS CLRED FOR 7500' AND UNDERSTOOD THAT I SHOULD ADVISE HIM WHEN MY JUMPERS WERE OUT. SOME CTLRS LIKE A 1 MIN WARNING UNTIL JUMPERS ARE OUT, BUT I DID NOT ASK HIM (THE CTLR) IF HE WANTED THAT, SO I ACKNOWLEDGED HIM. I TURNED ONTO JUMP RUN HDG WESTBOUND APPROX 1/2 MI N OF THOMPSON FIELD. THERE WAS SOME CONVERSATION BTWN THE CTLR AND THE SMA. I CAN'T RECALL EXACTLY WHAT IT WAS, BUT TO THE BEST OF MY KNOWLEDGE, I THOUGHT I HEARD THE CTLR SAY TO THE INBND SMA THAT HE WOULD BE GIVEN VECTORS AROUND MY POS. I COULDN'T REALLY TALK TO THE CTLR AT THIS TIME BECAUSE OF HIM TALKING TO THE SMA AND MY WORKLOAD. I TURNED MY AIRPLANE HDG MORE N WESTBOUND, NOW LOOKING FOR TFC. STILL NO SMA IN SIGHT. AT THIS TIME I WAS ABOUT 1/2 MI NW OF THOMPSON FIELD AND MY JUMPERS MADE THEIR EXIT. I CALLED QUAD CITY APCH AND TOLD THEM MY JUMPERS WERE OUT. THE CTLR WANTED TO KNOW WHY I DIDN'T ADVISE HIM WHEN I WAS 1 MI PRIOR TO JUMPERS AWAY, AND I TOLD HIM THAT I UNDERSTOOD HIM TO SAY TO ADVISE WHEN JUMPERS WERE OUT. AT THAT TIME I SAW THE TFC, AN SMA, FLY OVER THE 2 JUMPERS WHO WERE OVER THE DROP ZONE AT THOMPSON FIELD, UNDER CANOPY, AND I TOLD THE CTLR THIS. HE DID SAY THEN THAT SOME CTLRS LIKE 1 MIN PRIOR TO JUMP NOTIFICATION, ALTHOUGH HE SAID, "THAT DOESN'T DO A WHOLE LOT FOR ME," OR I SHOULD KEEP MY GUYS IN THE AIRPLANE UNTIL TFC'S NO LONGER A FACTOR. HE SAID HE WAS PROBABLY CONFUSING HIMSELF. I TOLD HIM I WOULD COMPLY WITH WHATEVER PROCS HE NEEDED. IN THE FUTURE, I'LL GIVE MORE INFO TO THE CTLR, EVEN IF THE CTLR DOESN'T ASK FOR IT. AS I MENTIONED ABOVE, THERE WAS SOME COM BTWN THE CTLR AND THE SMA. I JUST DIDN'T HEAR VERY WELL. I SAW NO TFC BEFORE THE JUMPERS EXITED. ABOUT FACTORS AFFECTING HUMAN PERFORMANCE, DON'T TAKE SOMETHING FOR GRANTED; IF IN DOUBT, ASK FOR CLARIFICATION!

SYNOPSIS: REPORTER DROPS JUMPERS IN THE PATH OF ONCOMING TRAFFIC.

REFERENCE FACILITY ID:MLI  
FACILITY STATE: IL  
DISTANCE & BEARING FROM REF.: 33,70  
MSL ALTITUDE: 7500,7500

ACCESSION NUMBER: 110010  
 DATE OF OCCURRENCE: 8905  
 REPORTED BY: FLC; FLC; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; ARTCC,RDR; ARTCC, SUPVR;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:BSY  
 FACILITY STATE: FL  
 FACILITY TYPE: ARTCC;  
 FACILITY IDENTIFIER: ZMA;  
 AIRCRAFT TYPE: MLG;  
 ANOMALY DESCRIPTIONS: ALT DEV/UNDERSHOOT ON CLB OR DES; NON ADHERENCE  
 LEGAL RQMT/CLNC;  
 ANOMALY DETECTOR: ATC/CTLR;  
 ANOMALY RESOLUTION: CTLR INTERVENED; CTLR ISSUED NEW CLNC;  
 ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
 NARRATIVE: FLT ABC AT 35000', CRUISE. FLT RECEIVED WHAT WE  
 BELIEVED TO BE A CLRNC TO DSND TO 240 FROM ZMA. COMMENCED OUR  
 DSNT AND AT APPROX FL340 ZMA ISSUED A CLRNC TO LEVEL OFF AT FL330  
 AND QUESTIONED WHY WE WERE DSNDING. AFTER EXPLAINING THAT WE HAD  
 ACKNOWLEDGED THE CLRNC TO FL240. HE SAID WE HAD TAKEN A CLRNC FOR  
 COMPANY FLT AGC AND AT THAT TIME THE CAPT FOR AGC CAME ON THE AIR  
 AND TOLD ZMA THAT HE HAD NOT RECEIVED OR ACKNOWLEDGED ANY CLRNC.  
 THERE WAS NO REPLY FROM ZMA. A SHORT TIME PASSED AND ZMA CALLED  
 COMPANY AGC AND CLRED THEM TO FL240. WE THEN RETURNED CALLS TO  
 ZMA AND REQUESTED THE CTLR'S NAME, PHONE # CONTACT AND ASKED IF  
 THERE WAS ANY CONFLICT WITH OTHER ACFT OR LOSS OF SEP. HE STATED  
 THERE WAS NONE. I THEN QUESTIONED SEVERAL PLTS ON THE GND IN MIA  
 WHO WERE INBND AND ON THE SAME FREQ AND THEY INDICATED THEY HAD  
 HEARD THE SAME THING WE DID. I THEN NOTIFIED COMPANY LEGAL DEPT,  
 SAFETY DEPT, VP OF FLT OPS AND REQUESTED A COPY OF ZMA'S TAPES.  
 THE FOLLOWING DAY I DISCUSSED THE INCIDENT WITH AREA SUPVR ZMA.  
 HE TOLD ME THE SAME INFO AS ABOVE (NO LOSS OF SEP), BUT SAID WE  
 HAD MISTAKENLY ACCEPTED, ACKNOWLEDGED AND COMPUTED WITH THE CLRNC  
 FOR COMPANY AGC AND HIS CTLR HAD NOT CAUGHT IT AND CORRECTED US.  
 HEREIN LIES THE PROB: 80-90% OF THE TIME, ESPECIALLY IN HIGH  
 DENSITY, EXTREMELY BUSY SECTORS, CLRNCS ARE RECEIVED,  
 ACKNOWLEDGED AND NOT CONFIRMED BY ATC. EXAMPLE: (ATC)-ACR LMN CLB  
 AND MAINTAIN 15 THOUSAND." (ACR LMN)-LEAVING 10 THOUSAND FOR 15  
 THOUSAND." --SILENCE-- DID ATC HEAR HIM? WAS THE CLRNC CORRECT?  
 BOTH ATC AND THE ACR ARE GUILTY OF THIS. WE MUST START  
 EMPHASIZING THE IMPORTANCE OF THAT FINAL CONFIRMATION FOR THE PLT  
 AND THE CTLR.  
 SYNOPSIS: ACR MLG CLRNC RESPONSE TO WRONG CALL SIGN OR  
 ARTCC RADAR TLR USED THE WRONG CALL SIGN RESULTING IN DESCENT  
 FROM CLRNC ALT.  
 REFERENCE FACILITY ID:BSY  
 FACILITY STATE: FL  
 DISTANCE & BEARING FROM REF.: 150,,N  
 MSL ALTITUDE: 33000,35000

ACCESSION NUMBER: 115928  
DATE OF OCCURRENCE: 8907  
REPORTED BY: FLC; ; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PIC.CAPT; TWR, LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SEA  
FACILITY STATE: WA  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: SEA; SEA;  
AIRCRAFT TYPE: MLG; MLG;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; RWY  
TRANSGRESS/OTHER;  
ANOMALY DETECTOR: ATC/CTLR; COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC ABORTED TKOF;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;

NARRATIVE: AFTER LNDG ON RWY 16R IN SEA WE WERE CLEARED TO  
CROSS RWY 16L AND TOLD TO CONTACT GND WHEN CROSSED. WHILE WE ARE  
APCHING AND VERY CLOSE TO RWY 16R ON THE "HIGH SPEED" ACR Y WAS  
CLEARED FOR TKOF. WE BOTH THOUGHT HE WAS CLEARED FOR TKOF ON RWY  
16R. HE WAS TAKING OFF ON RWY 16L. BY THAT TIME WE WERE ON RWY  
16L. WE CLEARED THE RWY ASAP, AND ACR Y ABORTED HIS TKOF ROLL.  
THE CTLR INITIALLY BLAMED US FOR THE INCIDENT AND SAID HE HAD  
TOLD US TO "HOLD SHORT OF 16L". WE CALLED THE TWR. THEY "CHECKED  
THEIR TAPES" AND IT SHOWED IT WAS CTLR'S MISTAKE. WHEN LNDG OR  
TAKING OFF ON ARPT WHERE YOU HAVE TO CROSS ACTIVE RWYS, YOU  
BETTER LISTEN TO ATC UNTIL YOU ARE AT THE GATE.

SYNOPSIS: ACR MLG WAS CLEARED FOR TKOF AT THE SAME TIME  
ANOTHER ACR WAS CLEARED TO CROSS THE RWY. ACFT ON TKOF ABORT.

REFERENCE FACILITY ID:SEA  
FACILITY STATE: WA  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 119378  
DATE OF OCCURRENCE: 8908  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; TWR,LC; TWR,SUPVR;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:PWK  
FACILITY STATE: IL  
FACILITY TYPE: TWR;  
FACILITY IDENTIFIER: PWK;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: OTHER; CONFLICT/GROUND LESS SEVERE; RWY  
TRANSGRESS/OTHER;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT; NOT  
RESOLVED/INSUFFICIENT TIME;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
NARRATIVE: AFTER VIS APCH TO RWY 16 AT PWK I WAS "CLRED TO  
LAND, HOLD SHORT SECOND RWY 24 FOR DEPARTING TFC." I COMPLIED,  
THEN WAS INSTRUCTED TO TAXI UP RWY 12L AND TO STAY WITH TWR. I  
DID NOT HEAR A TAXI CLRNC LIMIT TO HOLD SHORT OF RWY 24 AGAIN FOR  
DEPARTING TFC, ALTHOUGH I DID HEAR AN SMA Y LNDG BEHIND ME GIVEN  
A CLRNC LIMIT FOR LNDG ROLL-OUT RE: RWY 24. UPON MY CROSSING RWY  
24 I SAW AN SMA Z LNDG (?-FLAPS OUT) AND CTLR YELLED THAT I WAS  
TOLD TO HOLD SHORT OF RWY, "...CALL TWR ON PHONE." I DID SO. GND  
CTLR ANSWERED (HE WAS "CIL") AND ASKED WHAT HAPPENED.I EXPLAINED  
THAT I HAD NOT HEARD TAXI LIMIT, I WAS FAMILIAR (VERY) WITH ARPT  
AND VERY COMFORTABLE WITH RADIO PROC. I HAD HEARD SMA Y LNDG  
AFTER I WAS GIVEN ROLL-OUT RESTRICTION. HE SAID THEY WOULD NOT  
FILE AN ACTION, BUT THAT BOTH CTLR AND I SHOULD LISTEN-UP.  
SYNOPSIS: GA-SMA CROSSED AN ACTIVE RWY WITH SMA ON SHORT  
FINAL.  
REFERENCE FACILITY ID:PWK  
FACILITY STATE: IL  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 147237  
 DATE OF OCCURRENCE: 9006  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TWR,LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:LAX  
 FACILITY STATE: CA  
 FACILITY TYPE: ARPT; TWR; TWR;  
 FACILITY IDENTIFIER: LAX; LAX; LAX;  
 AIRCRAFT TYPE: MLG;  
 ANOMALY DESCRIPTIONS: RWY TRANSGRESS/OTHER; OTHER; NON ADHERENCE LEGAL  
 RQMT/CLNC;  
 ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
 ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;  
 ANOMALY CONSEQUENCES: NONE;  
 SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;  
 NARRATIVE: DISTANCE FROM GATE TO ACTIVE RWY ABOUT 300 YDS.  
 GND HAD US CONTACT TWR FROM PUSHBACK AREA. VERY BUSY WITH WT AND  
 BAL, CHKLIST, FMC, ETC. I UNDERSTOOD TAXI INTO POS AND HOLD,  
 WHICH I DID AFTER LOOKING TO E FOR INBND. F/O LATER SAID THE  
 CLRNC WAS FOR ANOTHER ACFT ON THE S SIDE OF THE ARPT SINCE THE  
 TWR WAS COMBINED OPERATION. F/O THOUGHT WE WERE SUPPOSED TO HOLD  
 SHORT, BUT DIDN'T SEE WHAT WE WERE DOING DUE TO COCKPIT WORKLOAD.  
 AS I STARTED ONTO THE RWY, ABOUT 1/2 PLANE ONTO RWY, TWR CLRED US  
 INTO POS TO HOLD. I THINK I SHOULD PAY MORE ATTN WHEN AT A LARGE  
 MULTI RWY ARPT WHEN THE OTHER PLANE ON ANOTHER TKOF RWY MAYBE 1  
 1/2 MI AWAY AND OTHERWISE NOT IN SIGHT MAKING ME BELIEVE THE  
 CLRNC MUST BE FOR ME, SINCE I'M THE ONLY PLANE HERE. WOULD BE  
 HELPFUL IF THE TWR ALSO ADVISED OF THEIR COMBINED UP FREQS. ALSO  
 WHEN THE OTHER PLANE ON THE OTHER RWY 1 1/2 MI AWAY ACKNOWLEDGES  
 THE CLRNC, YOU DON'T HEAR HIM, SINCE HE'S ON ANOTHER FREQ.  
 SYNOPSIS: UNAUTH RWY ENTRY.  
 REFERENCE FACILITY ID:LAX  
 FACILITY STATE: CA  
 AGL ALTITUDE: 0,0

ACCESSION NUMBER: 154200  
 DATE OF OCCURRENCE: 9008  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC, CAPT. PIC; FLC, FO; TRACON, AC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID: DCA  
 FACILITY STATE: DC  
 FACILITY TYPE: TRACON; ARPT;  
 FACILITY IDENTIFIER: DCA; DCA;  
 AIRCRAFT TYPE: LRG;  
 ANOMALY DESCRIPTIONS: OTHER; TRACK OR HDG DEVIATION; ALT DEV/EXCURSION  
 FROM ASSIGNED;  
 ANOMALY DETECTOR: ATC/CTLR;  
 ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC; NOT RESOLVED/DETECTED  
 AFTER-THE-FACT;  
 ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
 SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;  
 NARRATIVE: WE WERE IN RADIO CONTACT WITH WASHINGTON APCH  
 CTL ON A DOWNWIND LEG FOR RWY 36 AT WASHINGTON NATIONAL ARPT AT  
 3000' MSL, HDG 180 DEG AT 210 KTS AS ASSIGNED. THERE WERE APPROX  
 2 OTHER ACFT ON FREQ INBND TO DCA AT THE TIME. PRIOR TO TURNING  
 BASE LEG, WASHINGTON APCH CTLR INSTRUCTED US TO RESET OUR SQUAWK  
 AND DSND TO 2500'. WHILE IN THE DSNT TO 2500', WE WERE INSTRUCTED  
 TO TURN R TO 230 DEG. AFTER LEVELING AT 2500' ANOTHER CTLR  
 INSTRUCTED US TO "CLB TO 3000' AND TURN BACK L TO 170 DEG." WE  
 IMMEDIATELY COMPLIED BUT AT NO TIME DID WE VISLY PICK UP ANY  
 CONFLICTING TFC AND WE WERE PUZZLED BY THE SUDDEN CHANGE IN  
 VECTOR AND ALT. WE WERE FINALLY VECTORED ONTO THE FINAL APCH FOR  
 RWY 36 AND THE FINAL CTLR THEN CAME ON THE FREQ TO EXPLAIN TO US  
 THAT WE HAD TAKEN ANOTHER ACFT'S SQUAWK AND ALT WITH A SIMILAR  
 CALL SIGN ON A DISCREET FREQ. WE CONTINUED TO A LNDG AT DCA AND  
 AFTER ARR AT THE GATE I PROCEEDED TO OUR OPS OFFICE AND CALL  
 WASHINGTON APCH CTL. I SPOKE WITH THE SUPVR AND HE EXPLAINED  
 THAT THE APCH CTLR ON DUTY WAS WORKING A MIL FLT INBND TO ANDREWS  
 AFB ON A DISCREET FREQ WITH A SIMILAR CALL SIGN AND THE CTLR  
 FAILED TO ADVISE US OF THE SIMILAR CALL SIGN THAT HE WAS WORKING.  
 WE READ BACK EACH CLRNC CLRLY USING OUR COMPLETE CALL SIGN AND AT  
 NO TIME WERE WE AWARE OF TAKING THE CLRNC FOR ANOTHER ACFT NOR  
 WERE WE AWARE OF ANOTHER ACFT ON APCH WITH A SIMILAR CALL SIGN.  
 ATC PCH CTL FACS AT CONGESTED ARPTS SUCH AS WASHINGTON NATIONAL  
 SHOULD BE STAFFED SUFFICIENTLY SO THAT IT IS NOT NECESSARY FOR 1  
 CTLR TO WORK SEVERAL FLTS ON SEPARATE FREQS. AS A MINIMUM THE  
 CTRL SHOULD BE REQUIRED TO ADVISE ALL ACFT THAT HE IS WORKING IN  
 HIS SECTOR THAT HE IS USING SEPARATE FREQS AND HE HAS SIMILAR  
 CALL SIGNS.  
 SYNOPSIS: FLT CREW OF ACR LGT ARRIVING DCA APPARENTLY  
 TAKES CLRNC INTENDED FOR ANOTHER ACFT WITH A SIMILAR CALL SIGN ON  
 A UHF FREQ. LGT DESCENDS AND TURNS TOO SOON.  
 REFERENCE FACILITY ID: DCA  
 FACILITY STATE: DC  
 DISTANCE & BEARING FROM REF.: 10,, SE  
 MSL ALTITUDE: 2500, 3000

ACCESSION NUMBER: 159430  
DATE OF OCCURRENCE: 9010  
REPORTED BY: FLC; ; ; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PIC.CAPT; ARTCC,RDR;  
ARTCC,RDR; ARTCC,SUPVR;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID: BAL  
FACILITY STATE: MD  
FACILITY TYPE: ARTCC;  
FACILITY IDENTIFIER: ZNY;  
AIRCRAFT TYPE: MLG; LRG;  
ANOMALY DESCRIPTIONS: OTHER; ALT DEV/EXCURSION FROM ASSIGNED; NON  
ADHERENCE LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: CTLR INTERVENED; CTLR ISSUED NEW CLNC;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: PROCEEDING DIRECT BAL ON MY CTR AT FL180, I WAS  
FLYING (COPLT, F/O). CAPT WAS TALKING TO CTR. I STARTED A PA  
ANNOUNCEMENT TO THE PAX. I HEARD ATC "...ACA DSND AND MAINTAIN  
16000 ALTIMETER 30.04" CAPT READ BACK THE CLRNC AND I STARTED  
DSNT AND FINISHED PA. AT 17500' MSL, FEMALE VOICE CALLED CHK ALT  
SHOWING 17500'. CAPT REPLIED THAT WE RECEIVED CLRNC TO 16000'.  
MALE VOICE (EXCITED!) SAYS "THAT WAS FOR ANOTHER ABCA" THEN CTR  
MALE VOICE "ABCA START YOUR DSNT NOW" (NO CO ID). CTR "ACR X ABCA  
L TURN HDG 110 DEG". I STARTED TURN IMMEDIATELY BUT DID NOT KNOW  
WHAT ALT. LOTS OF CONFUSION WITH CTR. 2 MALE VOICES AND 1 FEMALE  
VOICE NOW. WE ASK AND GET 17000' AND FIND OUT ACR Y ABCA WAS ON  
FREQ. NO ONE TOLD US NOR DID WE HEAR ANY PREVIOUS XMISSIONS TO  
ACR Y. WE READ BACK ACR Y'S CLRNC AND CTR DID NOT CATCH IT NOR  
DID ACR Y SAY ANYTHING. CTR MADE SEVERAL XMISSIONS DURING THE  
EXCITEMENT USING JUST "ABCA" NO COMPANY NAME WHICH ADDED MORE  
CONFUSION SINCE THERE WERE TWO ABCA'S IN THE MIDDLE OF ALT PROB  
ASSIGNMENTS CTR WAS MAKING IT WORSE. ACR Y ABCA WAS HANDED OFF OT  
CTR 128.7. WE WERE HANDED OFF TO 128.7. 128.7 DID NOT SAY  
ANYTHING ABOUT SIMILAR CALL SIGNS EITHER. THE NEXT SECTOR WASH  
APCH 124.2 ANNOUNCED SIMILAR CALL SIGNS. CTR WAS NOT CAUTIOUS  
ABOUT FULL CALL SIGNS. EVEN WHEN THERE WAS A PROB, CTR STILL DID  
NOT USE FULL CALL SIGNS. CTR APOLOGIZED FOR THE PROB ON HDOF. (WE  
CALLED COMPANY TO HAVE OUR FLT NUMBER CHANGED FOR FUTURE FLTS).

SYNOPSIS: MLG REPLIED TO WRONG CALL SIGN AND STARTED  
DESCENT, CTLR CAUGHT AND TRIED TO CORRECT, BUT CTLR PHRASEOLOGY  
ONLY CONTINUED TO CONFUSE THE MLG, SUPVR FINALLY STRAIGHTENED IT  
OUT.

REFERENCE FACILITY ID: BAL  
FACILITY STATE: MD  
DISTANCE & BEARING FROM REF.: 55,,N  
MSL ALTITUDE: 17000,18000

ACCESSION NUMBER: 190584  
 DATE OF OCCURRENCE: 9110  
 REPORTED BY: FLC; FLC; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; FLC, PIC.CAPT;  
 TRACON, DC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:LAX  
 FACILITY STATE: CA  
 FACILITY TYPE: ARPT; TRACON;  
 FACILITY IDENTIFIER: LAX; LAX;  
 AIRCRAFT TYPE: WDB;  
 ANOMALY DESCRIPTIONS: TRACK OR HDG DEVIATION; NON ADHERENCE LEGAL  
 RQMT/CLNC;  
 ANOMALY DETECTOR: OTHER; COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC RETURNED ACFT TO ORIGINAL CLNC OR INTENDED  
 COURSE;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: CLRED TO TURN TO HDG 235 DEG AT SHORELINE  
 MAINTAIN 2000 FT ON A LOOP 8 DEP. AT ABOUT 900 FT TCASII ALARM --  
 TFC, TFC SOUNDED TWICE, NO ACFT IN SIGHT. TURNED TO HDG 235 DEG  
 AND WAS CHANGED TO DEP CTL AND AS SOON AS THE FREQ WAS SET CTLR  
 GAVE HDG OF 160 DEG CLB TO 13000. FO ACKNOWLEDGED, READ BACK  
 CLRNC. L TURN WAS BEGUN AND THE FLT, WHO WE WERE FOLLOWING, ASKED  
 WHO THE CLRNC WAS FOR AND DEP RESPONDED THAT IT WAS FOR THEM. WE  
 STOPPED THE TURN AT 210 DEG AND RETURNED TO THE ASSIGNED HDG AND  
 CONTINUED THE DEP. ALTHOUGH IT IS NOT USUAL TO GET A CLRNC FOR A  
 TURN THAT EARLY, I THOUGHT THAT THEY MAY BE TURNING US TO CLR THE  
 TFC ON TCASII.  
 SYNOPSIS: ACR WDB TRACK HDG DEV ON SID OUT OF LAX.  
 REFERENCE FACILITY ID:LAX  
 FACILITY STATE: CA  
 DISTANCE & BEARING FROM REF.: 2,,W  
 MSL ALTITUDE: 900,2000

ACCESSION NUMBER: 196903  
DATE OF OCCURRENCE: 9112  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; ARTCC,RDR;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:LMN  
FACILITY STATE: IA  
FACILITY TYPE: ARTCC;  
FACILITY IDENTIFIER: ZMP;  
AIRCRAFT TYPE: LTT;  
ANOMALY DESCRIPTIONS: ALT DEV/EXCURSION FROM ASSIGNED; NON ADHERENCE  
LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: CTLR INTERVENED;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: I UNDERSTOOD CTLR ISSUE US A DSCNT FROM 15000 TO  
11000. INSTRUCTED FO (PNF) TO REQUEST 7000 FT. ATC TOLD US TO  
STANDBY. I THEN BEGAN DSCNT TO 11000 FT. APPROX 13000 FT ATC  
ASKED US IF WE HAD BEGUN DSCNT. FO RESPONDED WE WERE DSNDING TO  
11000 AS PREVIOUSLY INSTRUCTED. ATC INFORMED US THAT DSCNT  
INSTRUCTION WAS FOR ANOTHER COMPANY FLT, WHOSE FLT NUMBER WAS THE  
NUMBER WE HAD USED ON OUR IMMEDIATELY PRECEDING FLT. SINCE THAT  
FLT WAS ON ANOTHER FREQ, WE DID NOT HEAR A RESPONSE THAT WOULD  
HAVE CLUED US THAT IT WAS NOT OUR INSTRUCTION. I SHOULD HAVE  
EITHER WAITED FOR ATC TO REINSTRUCT US, OR ASKED IF THE  
TRANSMISSION WAS FOR US OR NOT.  
SYNOPSIS: TOOK DSCNT CLRNC MEANT FOR ANOTHER ACFT.  
REFERENCE FACILITY ID:LMN  
FACILITY STATE: IA  
MSL ALTITUDE: 13000,15000

ACCESSION NUMBER: 204663  
 DATE OF OCCURRENCE: 9203  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; TWR,LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:DEN  
 FACILITY STATE: CO  
 FACILITY TYPE: ARPT; TWR;  
 FACILITY IDENTIFIER: DEN; DEN;  
 AIRCRAFT TYPE: MLG;  
 ANOMALY DESCRIPTIONS: TRACK OR HDG DEVIATION; NON ADHERENCE LEGAL  
 RQMT/CLNC;  
 ANOMALY DETECTOR: ATC/CTLR;  
 ANOMALY RESOLUTION: FLC RETURNED ACFT TO ORIGINAL CLNC OR INTENDED  
 COURSE; CTLR INTERVENED; CTLR ISSUED NEW CLNC;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: DEN TWR CLRED US ON TO HOLD 35L. WE WAITED  
 APPROX 5 MINS FOR TKOF CLRNC. OUR INITIAL CLRNC WAS DENVER-1 SID  
 (RWY HDG 10000 FT). TWR GAVE INSTRUCTIONS TO AT LEAST 4 OTHER  
 ACFT (DEPARTING 35L AND R) TO MAINTAIN 7500 FT AND 010 DEG HDG.  
 WHEN WE WERE CLRED FOR TKOF, I THOUGHT I HEARD TWR SAY 010 DEG  
 7500 FT AFTER TKOF, TURNED 20 DEG R TO 010 DEGS. TWR THEN QUERIED  
 AND TOLD US TO TURN BACK TO 350 DEG 7500 FT. NO CONFLICTS. THINK  
 TWR SHOULD CLR US RWY HDG 7500 FT IN THIS SITUATION DUE TO THE  
 LARGE NUMBER OF PREVIOUS ACFT BEING ISSUED 010 DEG HDG. THIS  
 WOULD HELP TREMENDOUSLY, BECAUSE I WAS PROBABLY UNDER THE  
 PRECONCEIVED MINDSET OF A 010 DEG HDG.  
 SYNOPSIS: HDG TRACK DEV IN NON ADHERENCE TO AN ATC CLRNC  
 INSTRUCTION.  
 REFERENCE FACILITY ID:DEN  
 FACILITY STATE: CO  
 DISTANCE & BEARING FROM REF.: 1,,N  
 AGL ALTITUDE: 1000,1000

ACCESSION NUMBER: 210241  
DATE OF OCCURRENCE: 9205  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT; TRACON,AC;  
FLIGHT CONDITIONS: MXD  
REFERENCE FACILITY ID:SLI  
FACILITY STATE: CA  
FACILITY TYPE: TRACON; ARPT;  
FACILITY IDENTIFIER: SNA; FUL;  
AIRCRAFT TYPE: SMT; SMA;  
ANOMALY DESCRIPTIONS: RWY OR TXWY EXCURSION; RWY TRANSGRESS/OTHER;  
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
ANOMALY RESOLUTION: CTLR INTERVENED;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: I WAS MAKING THE VOR APCH TO FULLERTON AND WAS BEING VECTORED TO FINAL BY COAST APCH. I WAS AT 3000 ASSIGNED ND HAD JUST BEEN GIVEN APCH CLRNC AND A TURN TO FINAL. I BEGAN THE TURN AS NORMAL AT WHICH TIME THE CTLR REQUESTED A GOOD RATE OF TURN. I IMMEDIATELY DISENGAGED THE AUTOPLT AND ROLLED INTO A 45 DEG TURN. DURING THIS APCH PERIOD I HEARD ANOTHER ACFT ALSO ON FREQ. THE SMA Y WAS ALSO AT 3000 AND BEING VECTORED FOR THE APCH. I BELIEVED HIM TO BE TO THE NW OF MY POS ALTHOUGH HE WAS NEVER GIVEN AS TFC. I WAS BTWN LAYERS, BUT DID NOT SEE ANY TFC. I COMPLETED THE APCH AND LNDG WITHOUT INCIDENT. WHILE ON THE RAMP I WAS APCHED BY THE PLT OF THE SMA Y, HE APPEARED VERY SHAKEN. HE INDICATED THAT WE HAD MISSED COLLIDING BY ABOUT 200-500 FT WHILE I WAS TURNING TO FINAL. HE THOUGHT THAT I HAD SEEN HIM AND TURNED SHARPLY TO AVOID HIM. I WAS NOT AWARE HE WAS THERE. HE DID NOT SEE ME UNTIL HE SAW THE BELLY OF THE SMT X IN THE TURN. WE WERE BOTH IFR AND NEITHER OF US HAD BEEN GIVEN THE OTHER AS TFC.

SYNOPSIS: SMA PLT ALLEGES THAT HE HAD AN NMAC WITH SMT WHILE ON APCH TO FUL ARPT, BOTH ACFT ON IFR FLT PLANS.

REFERENCE FACILITY ID:SLI  
FACILITY STATE: CA  
DISTANCE & BEARING FROM REF.: 3,20  
MSL ALTITUDE: 3000,3000

ACCESSION NUMBER: 217637  
 DATE OF OCCURRENCE: 9208  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PIC.CAPT; TWR, LC;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:ORD  
 FACILITY STATE: IL  
 FACILITY TYPE: ARPT; TWR; TWR;  
 FACILITY IDENTIFIER: ORD; ORD; ORD;  
 AIRCRAFT TYPE: MLG; WDB;  
 ANOMALY DESCRIPTIONS: OTHER; ERRONEOUS PENETRATION OR EXIT AIRSPACE;  
 NON ADHERENCE LEGAL RQMT/CLNC;  
 ANOMALY DETECTOR: ATC/CTLR;  
 ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;  
 ANOMALY CONSEQUENCES: FAA INVESTIGATORY FOLLOW-UP; FLC/ATC REVIEW;  
 SITUATION REPORT SUBJECTS: PHYSICAL FACILITY/ATC; PHYSICAL  
 FACILITY/ARPT; PROC OR POLICY/ATC FACILITY;  
 NARRATIVE: WE WERE AN XX00 PM DEP FROM ORD AND THE ARPT WAS  
 EXTREMELY BUSY. THE TWR CTLR WAS WORKING TKOFS USING FREQ 132.7  
 WHICH WAS NOT PUBLISHED ON THE ARPT PLATE. THERE WAS QUITE A BIT  
 OF STATIC ON THE RADIOS. THE PLANE AHEAD OF US WAS CLRED FOR TKOF  
 AND IT CAME IN STATICLY AND WHEN THE CREW ASKED FOR A  
 CLARIFICATION, THE CTLR CAME BACK IN A VERY SHARP TONE TO LISTEN  
 UP AND CLRED FOR TKOF. NEXT WE WERE CLRED INTO POS AND HOLD. OUR  
 CALL SIGN WAS ACR X, DXY. WE SAT ON THE RWY FOR ABOUT 2 MINS AND  
 THEN THOUGHT WE HEARD ACR X, DXY CLRED FOR TKOF. ONCE AGAIN, LIKE  
 THE PREVIOUS ACFT, THERE WAS STATIC ON THE RADIOS. I QUESTIONED  
 THE TKOF CLRNC DUE TO THE STATIC ON THE FIRST RECEPTION AND THE  
 CTLR REPLIED AFFIRMATIVE CLRED FOR AN IMMEDIATE TKOF, I WILL GIVE  
 YOU A TURN IN THE AIR. I THEN REPLIED ACR X, DXY ROLLING. AS SOON  
 AS WE WERE AIRBORNE, TWR CALLED US AND SAID ACR X, DXY WHAT ARE  
 YOU DOING? I NEVER CLRED YOU FOR TKOF, I CLRED ACR Y, FXY FOR  
 TKOF, YOU NEVER HAD A TKOF CLRNC. HE THEN LEFT US ON RWY HDG AND  
 SENT US TO DEP CTL. I NEVER THOUGHT SOMETHING LIKE THIS COULD  
 EVER HAPPEN TO ME. I HAVE READ ABOUT THIS HAPPENING AND HAVE  
 ALWAYS THOUGHT THAT IT WAS DUE TO INATTN BY THE PLTS AND A LACK  
 OF PROFESSIONALISM. BUT NOW I BELIEVE THAT, DUE TO THE INTENSE  
 SITUATION AND SOME SHORTCUTS IN RADIO TRANSMISSIONS, THAT THIS IS  
 A VERY EASY OCCURRENCE. SOME OF THE FACTORS INVOLVED IN THIS  
 SITUATION WAS FIRST, THE TWR CTLR WAS WORKING A SPLIT FREQ AND  
 WAS WORKING 2 RWYS -- 32L AND 32R. THE 2 FREQS WERE 132.7 FOR 32L  
 AND 126.9 FOR 32R. WE DID NOT KNOW HE WAS WORKING 2 RWYS AND  
 COULD NOT HEAR ANY REPLIES ON 126.9. WE DISCOVERED THIS WHEN THE  
 CAPT TALKED TO MR X, THE TWR SUPVR. WE BELIEVE THAT, DUE TO THE  
 RUSHED SITUATION IN TRYING TO GET ACR Y TO TKOF, THE CTLR DROPPED  
 THE PREFIX (ACR Y) AND THE SUFFIX (HVV) AND JUST XMITTED FXY.  
 WHEN I QUESTIONED THE TKOF CLRNC, MR X SAID BOTH US AND ACR Y  
 QUESTIONED IT AT THE SAME TIME WITH THE SAME VERBIAGE. THE CTLR  
 HEARD WHAT HE NEEDED TO HEAR AND THEN CLRED FXY FOR AN IMMEDIATE  
 TKOF. SOME OF THE PROBLEMS WE THE 1)STATIC ON THE RADIOS, 2) THEY  
 WERE CLOSE TO PUTTING ANOTHER CTLR ON TO HANDLE THE OTHER RWY,  
 BUT DELAYED WAITING UNTIL IT GOT A LITTLE BUSIER. 3) WE DID NOT  
 KNOW ANOTHER SIMILAR SOUNDING CALL SIGN WAS BEING USED ON THE  
 ARPT OR THAT THE TWR CTLR WAS WORKING 2 RWYS. 4) NEXT, THE

(REPORT CONTINUED)

STRESSFUL TONE OF THE CTLR AND THE PROBLEM WITH THE PREVIOUS ACFT THAT TOOK OFF FROM 32L PUT US IN A HURRY STATE OF MIND. 5) NEXT, THE CTLR, EITHER DUE TO THE STATIC OR BEING UNDER A LOT OF PRESSURE, STARTED TO TAKE SHORTCUTS IN THE CALL SIGN BECAUSE WE NEVER HEARD HIM USE ACR Y FXY HVY CLRED FOR TKOF, EITHER THE ACR Y OR HVY WOULD HAVE FLAGGED US THAT HE HAD NOT CLRED US FOR TKOF. ANOTHER ACR X ACFT BEHIND US FOR TKOF ON 32L. AFTER WE WERE AIRBORNE AND THE TWR SAID HE DID NOT CLR US FOR TKOF, THE OTHER ACR ACFT SAID THAT, YES, HE DID CLR US, ACR X, DXY, FOR TKOF. THEREFORE, HE HAD HEARD THE SAME CLRNC WE HEARD. I ACCEPT 1/2 THE RESPONSIBILITY FOR THIS OCCURRENCE BECAUSE I NORMALLY AM VERY SPECIFIC IN ACKNOWLEDGING CLRNCs USING OUR FULL CALL SIGN AND CLRNC. IN THIS OCCURRENCE, I THOUGHT A CONFLICT WAS ABOUT TO OCCUR DUE TO THE TRANSMISSION OF 'CLRED FOR AN IMMEDIATE' TKOF THAT TO EXPEDITE, I SHORTENED MY REPLY TO X, DXY ROLLING INSTEAD OF ACR X DXY CLRED FOR TKOF FROM 32L. THE BEST LESSON LEARNED IS NEVER GET CAUGHT UP IN GO, GO STATE OF MIND AND ALWAYS SIT BACK AND TAKE YOUR TIME TO BE SURE YOU HEAR WHAT YOU ARE SUPPOSED TO HEAR.

SYNOPSIS: UNAUTHORIZED TKOF RWY OP RESULTS IN UNAUTHORIZED UNCOORD PENETRATION OF AIRSPACE. PROX OF ATA TCA.

REFERENCE FACILITY ID:ORD

FACILITY STATE: IL

AGL ALTITUDE: 0,0

ACCESSION NUMBER: 241011  
 DATE OF OCCURRENCE: 9305  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; ARTCC,RDR; FLC, PIC.CAPT;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:LAX  
 FACILITY STATE: CA  
 FACILITY TYPE: ARTCC; ARPT;  
 FACILITY IDENTIFIER: ZLA; LAX;  
 AIRCRAFT TYPE: SMT; WDB;  
 ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL  
 SEPARATION; ALT DEV/OVERSHOOT ON CLB OR DES; NON ADHERENCE LEGAL  
 RQMT/CLNC;  
 ANOMALY DETECTOR: ATC/CTLR;  
 ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;  
 ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
 NARRATIVE: DURING CRUISE I HEARD ZLA TELL ACR X (DSNDING)  
 TO LGB 'PLAN ON 35 DME N OF SXC (SANTA CATALINA VOR) AT 11000  
 FT.' I MADE NOTE. AND SINCE WE WERE ON THE SAME ROUTING, I  
 FIGURED THEY WOULD GIVE US THE SAME ALT RESTRICTION. 3 MINS LATER  
 THEY SAID 'SMT PLAN ON 35 N OF SXC AT 11000 FT.' BOTH THE CAPT  
 AND I HAD REMOVED OUR HEAD SETS FOR THE 1.5 HR FLT. WE ALSO  
 TURNED OFF THE 'SIDE TONE' TO AVOID LOUD SQUEALS WHEN XMITTING.  
 WE HAD APPROX 75 KTS TAILWIND DURING OUR DSCNT. REALIZING I'D  
 BETTER START DOWN TO MEET THE RESTRICTION, WE ASKED CTR FOR  
 LOWER. THE CTLR SAID 'SMT DSND AND MAINTAIN 11000 FT.' AT THIS  
 POINT I BEGAN CALCULATING WHAT RATE OF DSCNT WOULD BE REQUIRED TO  
 MEET THE 35 N AT 11000 FT RESTRICTION. (IN HINDSIGHT, THE CTLR  
 NEVER GAVE US THE RESTRICTION, JUST PLAN ON IT.) SINCE THE CTLR  
 SAID PLAN ON THE RESTRICTION, I WAS BUSY PLANNING THE DSCNT.  
 AFTER WE HAD STARTED DOWN I FAILED TO HEAR A CALL FROM CTR AND  
 FAILED TO HEAR THE CAPT READ BACK THE CLRNC 'SMT DSND AND  
 MAINTAIN 13000 FT FOR TFC AT 12000 FT.' AGAIN WE HAD OUR SIDE  
 TONE TURNED OFF. SINCE THE ALT ALERTER IS CLOSER TO THE FO SIDE  
 OF THE COCKPIT, I USUALLY SET THE CLRNC ALT. BUT THE LAST CLRNC I  
 HEARD WAS 11000 FT, THAT REMAINED IN THE ALERT BOX. AS WE  
 CONTINUED THE DSCNT, CTR CALLED OUT TFC AS AN ACR WDB AT 12  
 O'CLOCK, 'DO WE HAVE HIM IN SIGHT?' WE RESPONDED 'AFFIRMATIVE,  
 WDB IN SIGHT.' DSNDING THROUGH 11800 FT THE CTLR ASKED 'SMT, WHAT  
 IS YOUR ALT?' WE RESPONDED 11800 FT FOR 11000 FT.' SHE RESPONDED  
 'NEGATIVE, YOU WERE ASSIGNED 13000 FT.' 'SMT YOU WERE INVOLVED IN  
 A POTENTIAL PLT ALT VIOLATION. CONTACT CTR [WITH THE TELEPHONE  
 NUMBER] ON THE GND.' (ON THE TAPE, THE CAPT READ BACK 13000 FT,  
 BUT WE BOTH FAILED TO ADJUST THE ALT ALERTER.)  
 SYNOPSIS: COMMUTER ACFT DSNDLS BELOW ASSIGNED ALT.  
 REFERENCE FACILITY ID:LAX  
 FACILITY STATE: CA  
 DISTANCE & BEARING FROM REF.: 30,,W  
 MSL ALTITUDE: 11800,13000

**INSTRUCTIONAL PLI ELEMENTS: Incorrect Transmission, Correct Action**

ACCESSION NUMBER: 100800  
DATE OF OCCURRENCE: 8812  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PIC.CAPT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:LRD  
FACILITY STATE: TX  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: LRD; LRD;  
AIRCRAFT TYPE: SMA; SMT;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; LESS THAN LEGAL  
SEPARATION;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: WHEN APPROX 15 MI SE OF LRD FOR THE PURPOSE OF  
LNDG, I ANNOUNCED MY POS TO LRD TWR AND RECEIVED LNDG INFO AND  
WAS INSTRUCTED TO ENTER LEFT DOWNWIND FOR RWY 17R. I RPTED  
ENTERING LEFT DOWNWIND AND RECEIVED LNDG CLRNC AT THAT TIME.  
WHILE TURNING BASE, ANOTHER ACFT (TWIN TURBO PROP) WAS TAXIING  
FOR TKOF AND REPORTED READY AT THE END. AT THAT TIME THE TWR  
ISSUED TKOF CLRNC TO THE ACFT. WHILE TURNING FINAL, I SHINED MY  
LNDG LIGHT DIRECTLY AT THE ACFT SO I COULD BE EASILY SEEN. I HAD  
PLANNED MY APCH TO CROSS THE THRESHOLD AT APPROX 200' TO MINIMIZE  
MY TIME ON THE RWY. WHILE ON SHORT FINAL THE ACFT TAXIED EBND  
UNDER MY ACFT AND I PASSED OVER HIM AND LANDED. DURING MY FLAIR,  
THE TWR INSTRUCTED ME TO BREAK IT OFF DUE TO TFC CONFLICT. I TOLD  
THE TWR THAT THE OTHER ACFT HAD PASSED UNDER ME AND WAS OFF TO  
THE E OF RWY 17R AND VERIFIED CLRED TO LAND. DURING THIS TIME I  
WAS PREPARED TO EXECUTE A GO AROUND IN THE EVENT THE OTHER ACFT  
TAXIED ONTO THE RWY, BUT NO FURTHER EVASIVE ACTION WAS NECESSARY.  
AFTER I LANDED THE TWR COMMUNICATED TO THE OTHER ACFT THAT HE HAD  
TAXIED PAST THE ACTIVE RWY. AT THIS TIME THE OTHER ACFT STATED  
THAT HE HAD GONE BEYOND THE RWY AS EVASIVE ACTION TO AVOID  
CONFLICT AND STATED, "I GUESS HE JUST WANTED TO CUT US OUT." UPON  
HEARING THIS ATTITUDE, I STATED THAT I HAD NOT INTENDED TO CUT  
ANYONE OUT, BUT ONLY CONTINUED MY NORMAL APCH FOR WHICH I HAD  
BEEN CLRED TO LAND. I APOLOGIZED FOR ANY MISUNDERSTANDING AND  
STATED THAT I HAD SHINED MY LNDG LIGHT DIRECTLY AT HIM TO ENSURE  
THAT I WAS SEEN SINCE IT WAS OBVIOUS TO ME THAT WE WOULD BOTH  
NEED THE SAME PORTION OF THE RWY AT THE SAME TIME. DUE TO LIGHTS  
AROUND THE ARPTS, I CAN UNDERSTAND THAT THE TWR CTLR MAY NOT HAVE  
BEEN ABLE TO SEE THAT THE LNDG AND DEPARTING ACFT WERE ARRIVING  
AT THE END OF THE RWY AT THE SAME TIME. I FELT THAT THE DEPARTING  
ACFT WOULD HOLD FOR MY LNDG AND I WOULD TAXI CLR ASAP. EITHER THE  
DEPARTING ACFT DID NOT SEE ME OR FELT THAT THE DEPARTING ACFT HAD  
THE RIGHT OF WAY. IN MY OPINION, THE TWR OPERATOR SHOULD HAVE  
INSTRUCTED THE OTHER ACFT TO HOLD FOR LNDG TFC OR INSTRUCTED ME  
TO EXTEND MY PATTERN. NEITHER WAS DONE. IF I HAD QUERIED THE TWR  
REF MY LNDG CLRNC WHEN I SAW THE CONFLICT, I COULD HAVE CAUSED  
THE TWR TO CLARIFY LNDG OR TKOF CLRNCS. IN THE FUTURE, I WILL NOT

(REPORT CONTINUED)

ASSUME THE OTHER ACFT HAS VIS CONTACT WITH ME AND WILL COMMUNICATE ANY POSSIBLE CONFLICTS TO ATC. IF THE OTHER ACFT WAS READY FOR DEP WHEN HE CALLED INSTEAD OF SOME DISTANCE FROM THE RWY, HE WOULD HAVE BEEN OUT OF MY WAY BEFORE MY ARR. THE TWR COULD HAVE AVOIDED THE SITUATION BY BEING MORE AWARE OF TFC LOCATION. IN SUMMARY, ANY OF THE 3 PLAYERS COULD HAVE AVOIDED THE POTENTIALLY DANGEROUS SITUATION. FROM TWR COMS, IT WAS APPARENT THE TWR CTLR DID NOT KNOW THE POS OF HIS TFC WHILE ISSUING CLRNCS.

SYNOPSIS: LESS THAN STANDARD SEPARATION AND GND CRITICAL NMAC BETWEEN ATX AND TWIN GA ACFT. OPERATIONAL ERROR.

REFERENCE FACILITY ID:LRD

FACILITY STATE: TX

DISTANCE & BEARING FROM REF.: 1,,N

AGL ALTITUDE: 0,200

ACCESSION NUMBER: 115584  
 DATE OF OCCURRENCE: 8907  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC,SO; FLC,PIC.CAPT; FLC,PIC.CAPT; TWR, LC;  
 FLIGHT CONDITIONS: MXD  
 REFERENCE FACILITY ID:DFW  
 FACILITY STATE: TX  
 FACILITY TYPE: ARPT; TWR;  
 FACILITY IDENTIFIER: DFW; DFW;  
 AIRCRAFT TYPE: LRG; WDB;  
 ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/WX; OTHER;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: FLC ABORTED TKOF;  
 ANOMALY CONSEQUENCES: NONE;  
 SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;  
 NARRATIVE: WE WERE #3 FOR TKOF ON 17R FACING N ON THE OUTER  
 TXWY. AN ACR B WDB WAS IN POSITION ON 17R. DEP HAD BEEN STOPPED  
 BY CENTER, UNKNOWN CAUSE. WE WERE LOOKING AT TSTMS TO THE N OF  
 DFW APCHING. NO TSTM PRESENT TO THE S. AN ACR C WDB DEPARTED 17L  
 WITH ACR B STILL HOLDING. THE TSTM WAS APCHING WITH WIND AND RAIN  
 STARTING. ACR B WAS CLEARED FOR TKOF. THERE SEEMED TO BE SOME  
 CONFUSION IN TWR. WE WERE CONCERNED THAT ACR B DID NOT KNOW WHAT  
 WAS BEHIND THEM. MY CAPT THOUGHT THE ACR B CAPT WAS CRAZY FOR  
 ATTEMPTING THE TKOF SO HE ASKED FOR A WIND CHECK FROM TWR TO TRY  
 AND CLUE THE ACR B CAPT (THE TWR WAS BEHIND THE CURVE). THE TWR  
 SAID SOMETHING LIKE 15 KTS CENTER FIELD AND 35 KTS NORTH  
 BOUNDARY. THE ACR B CAPT GOT THE HINT AND REFUSED THE TKOF CLRNC.  
 WE SAT ON THE TXWY FOR THE NEXT 2 HRS. THE TSTM WAS LARGE,  
 IRREGULAR IN SHAPE, AND SEVERE. A MICROBURST COULD HAVE OCCURRED  
 CAUSING THE ACR B TO CRASH ON RWY 17 AT DFW. THE TWR OPERATORS  
 WERE UNDER PRESSURE TO GET AS MANY ACFT AIRBORNE BEFORE THE TSTMS  
 HIT. THIS INCIDENT WAS JUST TOO CLOSE. THE TWR OPERATORS DID NOT  
 HAVE A GOOD IDEA WHAT THE WX WAS DOING.  
 SYNOPSIS: ACR WDB REFUSED TKOF CLRNC WHEN PARTY LINE  
 CONVERSATION REVEALED POSSIBILITY OF WIND SHEAR DURING TKOF ROLL.  
 REFERENCE FACILITY ID:DFW  
 FACILITY STATE: TX  
 AGL ALTITUDE: 0,0

ACCESSION NUMBER: 134748  
DATE OF OCCURRENCE: 9001  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TRACON,DC; ARTCC, RDR;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SYR  
FACILITY STATE: NY  
FACILITY TYPE: ARPT; TRACON; ARTCC;  
FACILITY IDENTIFIER: SYR; SYR; ZNY;  
AIRCRAFT TYPE: MLG;  
ANOMALY DESCRIPTIONS: TRACK OR HDG DEVIATION; ALT DEV/EXCURSION FROM  
ASSIGNED; NON ADHERENCE LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: OTHER; COCKPIT/FLC;  
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: WE TOOK OFF E, WITH A DEP CLRNC OF RWY HDG AND  
UP TO 4000'. DEP CTL TURNED US TO 290 DEGS AND SWITCHED US TO  
CENTER FREQ. WE WERE CLRED TO 15000'. WE CHKED IN WITH CENTER AND  
ACKNOWLEDGED ALL CLRNCs USING OUR FLT ADDB CALL SIGN. AS WE CLBED  
THROUGH 6000', I WONDERED ABOUT THE FACT THAT 15000' WAS THE  
WRONG ALT. FOR OUR DIRECTION OF FLT AND ASKED THE F/O TO CONFIRM  
THE CLRNC. HE DID, USING OUR ADDB CALL SIGN, AND CENTER CONFIRMED  
THE 15000' ALT CLRNC, ACKNOWLEDGING OUR USE OF AND IN RETURN  
ADDRESSING US BY OUR ADDB CALL SIGN. AT THIS TIME ANOTHER FLT,  
EBND FLT XXDB, BROKE IN AND WONDERED IF MAYBE WE, FLT ADDB,  
HADN'T BEEN GETTING THEIR CLRNC. CENTER SUDDENLY REALIZED THEY  
HAD THE 2 FLT'S CONFUSED AND TOLD US, ADDB, TO LEVEL AT OUR  
PRESENT ALT (8500') AND RETURN TO DEP CTL FREQ. WE DID AND DEP  
APOLOGIZED FOR THE CONFUSION AND GAVE US ANOTHER CENTER FREQ. WE  
CONTACTED ANOTHER CENTER ON ANOTHER FREQ AND WERE CLRED TO  
10000', AND THEN TO 14000' AS FILED. SAFETY WAS NEVER  
COMPROMISED, THERE WERE NO CLOSE CALLS, AND NO ABRUPT OR EVASIVE  
ACTIONS WERE TAKEN, BUT THIS NARRATIVE AGAIN POINTS OUT THE PROBS  
INHERENT TO SIMILAR FLT #'S OPERATING IN THE SAME AREA AT THE  
SAME TIME. FLT XXDB HAD TAKEN OFF AHEAD OF US, AND WHILE IT IS  
POSSIBLE WE RESPONDED TO A FREQ SWITCH GIVEN BY DEP CTL TO XXDB,  
I BELIEVE DEP SWITCHED US ADDB, INSTEAD OF XXDB, TO CENTER FREQ  
AND CREATED THE CONFUSION. AT ANY RATE, WE CHKED IN ON FREQ USING  
OUR ADDB CALL SIGN, WERE ADDRESSED BY CENTER AS ADDB, AND  
RESPONDED AS ADDB. WE EVEN QUESTIONED AND ASKED FOR CONFIRMATION,  
AND RECEIVED IT AS ADDB. SUGGESTIONS AND SOLUTIONS: CENTER AND  
PROBABLY DEP CTL NEED TO PAY CLOSER ATTN TO FLT #'S. A CORRECT  
CLRNC GIVEN TO THE WRONG FLT IS ALMOST WORSE THAN NO CLRNC AT  
ALL. FLT CREWS MAYBE NEED TO BE A LITTLE QUICKER AND A LITTLE  
MORE FORCEFUL IN QUESTIONING THINGS WHEN THEY JUST DON'T SOUND  
RIGHT. THE FIRST PARTY AWARE OF PROX OF SIMILAR FLT #'S NEEDS TO  
BE SURE ALL INTERESTED PARTIES ARE EQUALLY AWARE OF THE FACT.

SYNOPSIS: ACR MLG CLRNC RESPONSE TO WRONG CALL SIGN. CLRNC  
READBACK HEARBACK.

REFERENCE FACILITY ID:SYR  
FACILITY STATE: NY  
DISTANCE & BEARING FROM REF.: , ,NW  
MSL ALTITUDE: 7000,7000

ACCESSION NUMBER: 160299  
DATE OF OCCURRENCE: 9010  
REPORTED BY: FLC; ; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; FLC, PIC.CAPT;  
TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SFO  
FACILITY STATE: CA  
FACILITY TYPE: ARPT; TWR;  
FACILITY IDENTIFIER: SFO; SFO;  
AIRCRAFT TYPE: WDB; ;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; NON ADHERENCE LEGAL  
RQMT/FAR; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: OTHER;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: WE WERE CLRED FOR TKOF ON SFO RWY 28L AND HAD  
REACHED ABOUT 15 KTS GNDSPD WHEN AN ACFT W OF US WAS CLRED TO  
CROSS RWY 28L. THE PLT OF THIS ACFT IMMEDIATELY CHALLENGED THIS  
CLRNC AND WAS TOLD TO HOLD SHORT OF RWY 28L. THIS SOLVED OUR PROB  
AND WE CONTINUED OUR TKOF. THIS IS RPTED AS AN EXAMPLE OF THE  
ALERTNESS AND SITUATIONAL AWARENESS ON THE PART OF THE PLT OF THE  
OTHER ACFT AND OF THE NEED FOR CAUTION AT ALL TIMES, ESPECIALLY  
AT TIMES OF HIGH CTLR WORKLOAD.  
SYNOPSIS: WITH AN ACR WDB ON TKOF ROLL ATCT LCL CTLR  
CLEARED ANOTHER ACFT TO CROSS THE ACTIVE DOWNFIELD. FLT CREW OF  
TAXIING ACFT QUESTIONED THE CLRNC AND ATCT LCL CTLR ADVISED THEM  
TO HOLD SHORT.  
REFERENCE FACILITY ID:SFO  
FACILITY STATE: CA  
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 184688  
 DATE OF OCCURRENCE: 9107  
 REPORTED BY: FLC; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TRACON,AC;  
 FLIGHT CONDITIONS: MXD  
 REFERENCE FACILITY ID: SMO  
 FACILITY STATE: CA  
 FACILITY TYPE: ARPT; TRACON;  
 FACILITY IDENTIFIER: LAX; LAX;  
 AIRCRAFT TYPE: MLG; MLG;  
 ANOMALY DESCRIPTIONS: NO SPECIFIC ANOMALY OCCURRED;  
 ANOMALY DETECTOR: COCKPIT/FLC;  
 ANOMALY RESOLUTION: CTLR INTERVENED; NOT RESOLVED/UNABLE;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: DURING VERY BUSY PERIOD OF IFR ARRS APCH CTL  
 ISSUED A CLRNC TO AN ACFT (UNKNOWN CALL SIGN) TO 'DSND TO 2500  
 FT'. THE OTHER AIRPLANE READ BACK 'CLRED TO 1500 FT'. APCH CTLR  
 MISSED THE ERROR AS HE WAS OVERLOADED. I ATTEMPTED TO TELL APCH  
 CTLR BUT TRANSMISSION WAS BLOCKED BY OTHER TRANSMISSIONS. I WAS  
 NOT SURE WHO THE WRONG CLRNC WAS FOR AND WRONGFULLY ASSUMED THAT  
 MODE C READOUTS WOULD KEEP EVERYONE OK. I KNEW THERE WAS CEILING  
 OF AROUND 1000 FT, AND RATIONALIZED THAT A TRAGEDY WOULD NOT  
 OCCUR. HOWEVER, THE CTLR DID NOT NOTICE THE ALT ERROR UNTIL 1500  
 FT, WHEN THE OFFENDING ACR WAS TOLD TO GO BACK TO 2500 FT. I  
 LEARNED 2 THINGS. I SHOULD HAVE INSISTED ON RELAYING THE ERROR TO  
 APCH, EVEN IF IT WAS ME WHO MISUNDERSTOOD. ALSO THE ACR DIDN'T  
 READ BACK CORRECTLY, TERMINOLOGY WISE. ('1500' APCH WOULD'VE  
 PROBABLY NOTICED.)  
 SYNOPSIS: ATTEMPTED TO ADVISE CTLR ACFT HAD COPIED CLRED  
 ALT WRONG.  
 REFERENCE FACILITY ID: SMO  
 FACILITY STATE: CA  
 MSL ALTITUDE: 7000,7000

ACCESSION NUMBER: 184723  
DATE OF OCCURRENCE: 9107  
REPORTED BY: FLC; FLC; ; ; ;  
PERSONS FUNCTIONS: FLC,SO; FLC,PIC.CAPT; FLC,PIC.CAPT; FLC, FO;  
ARTCC, RDR;  
FLIGHT CONDITIONS: IMC  
REFERENCE FACILITY ID:SAX  
FACILITY STATE: NJ  
FACILITY TYPE: ARTCC;  
FACILITY IDENTIFIER: ZBW;  
AIRCRAFT TYPE: WDB; WDB;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL  
SEPARATION; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;  
ANOMALY CONSEQUENCES: FAA INVESTIGATORY FOLLOW-UP;  
NARRATIVE: RADAR WAS OTS AT EWR BACKING UP TFC AT EWR.

BOSTON CENTER PLACED ACR X IN HOLDING PATTERN. ACR X WAS CLRED TO  
HOLD AT SHAFF INTXN AT 8000 FT. ACR Y SIMILAR NUMBER WAS ON FREQ.  
WE WERE ABOUT 20 MI FROM SHAFF WHEN BOSTON CENTER (128.67) CLRED  
US TO 7000 FT. THE FO READ IT BACK WITH NO RESPONSE. THE FO RPTED  
OUT OF 8000 FT FOR 7000 FT. NO RESPONSE FROM ATC. (THIS SECTOR  
WAS VERY BUSY AT THIS TIME). AS WE PASSED THROUGH 7600 FT, ACR Y  
QUESTIONED OUR ALT DIRECTLY TO US. WE SAID WE WERE OUT OF 8000 FT  
FOR 7000 FT. HIS RESPONSE WAS HE WAS AT 7000 FT AT SHAFF. ATC  
THEN PICKED UP ON THE PROBLEM AND REASSIGNED 8000 FT TO US. WE  
CLBED TO 8000 FT. APPROX 1 MIN LATER WE SAW ACR Y IN HIS HOLD  
OVER SHAFF. WHEN WE WERE FIRST ASSIGNED 7000 FT WE WERE IMC.

SYNOPSIS: ACR X HAD LTSS FROM ACR Y. SAME ALT ASSIGNED IN  
HOLDING PATTERN. SYS ERROR.

REFERENCE FACILITY ID:SAX  
FACILITY STATE: NJ  
DISTANCE & BEARING FROM REF.: 14,29  
MSL ALTITUDE: 7000,8000

ACCESSION NUMBER: 191230  
 DATE OF OCCURRENCE: 9110  
 REPORTED BY: FLC; ; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; ARTCC,RDR;  
 ARTCC,SUPVR;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:CCE  
 FACILITY STATE: FL  
 FACILITY TYPE: ARPT; ARTCC;  
 FACILITY IDENTIFIER: MIA; ZMA;  
 AIRCRAFT TYPE: LRG;  
 ANOMALY DESCRIPTIONS: LESS THAN LEGAL SEPARATION; NON ADHERENCE LEGAL  
 RQMT/PUBLISHED PROC; NON ADHERENCE LEGAL RQMT/FAR;  
 ANOMALY DETECTOR: ATC/CTLR; COCKPIT/FLC;  
 ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;  
 ANOMALY CONSEQUENCES: NONE;  
 NARRATIVE: I WAS THE CAPT ON ACR X, BOS TO MIA. WE WERE  
 HOLDING AT THE PUBLISHED PATTERN AT CCE ON THE COLLIER 2 ARR INTO  
 MIA AT FL260. THE INCIDENT TOOK PLACE AT XX00Z. WE HAD ENTERED  
 HOLDING AT FL240, THEN GIVEN A CLB TO FL250, THEN LATER, TO  
 FL260. DURING THIS TIME THE CTLR WAS GIVING AN EFC TO ALL ACFT IN  
 THE PATTERN OF XX05Z. I THOUGHT THIS WAS RATHER STRANGE AS I HAD  
 ALWAYS OBSERVED EACH ACFT RECEIVING AN INDIVIDUAL TIME. AS WE  
 WERE INBOUND ON HOLDING (10 MI LEGS OVER THE VOR) THE CTLR ISSUED  
 A DSCNT CLRNC TO AN ACR Y FLT TO FL250. I THOUGHT THIS STRANGE AS  
 WE SHOULD HAVE BEEN NEXT TO FL250. I ASKED THE CTLR IF HE WAS  
 HANDLING ANY OTHER HOLDING PATTERNS. HE SAID NO. NOW, AS WE WERE  
 HDG OUTBOUND (W) I TOLD HIM WE WERE AT FL260 AND WOULDN'T WE BE  
 NEXT TO FL250. AFTER A BRIEF PAUSE, ANOTHER VOICE CAME OVER THE  
 RADIO TELLING US TO TURN IMMEDIATELY TO A HDG OF 180 (S AND AWAY  
 FROM THE HOLDING PATTERN). WE HELD THIS HDG FOR ABOUT 1 MIN, THEN  
 WERE GIVEN A HDG OF 270, PARALLEL TO THE OUTBOUND LEG OF THE  
 PATTERN FOR ABOUT 2 MINS, THEN WERE GIVEN A TURN TO 360, THEN A  
 TURN TO JOIN THE INBOUND LEG OF THE PATTERN OF THE VOR. IN MY  
 OPINION, THE CTLR DSNDDED THE ACR Y THROUGH OUR ALT BLOCK. AS THEY  
 WERE ONLY 10 MI LEGS, WE MOST LIKELY WERE VERY CLOSE AS THE  
 VECTOR AWAY FROM THE PATTERN. THE CTLR NEVER MADE MENTION OF THE  
 POSSIBILITY OF A NEAR MISS, HOWEVER, ANOTHER CTLR'S VOICE  
 INDICATED SOMETHING WAS AMISS. EVEN THOUGH YOU CAN'T SEE ACFT,  
 IT'S GOOD TO LISTEN UP ON THE RADIO AND MAKE A MENTAL PICTURE OF  
 THE ACFT AROUND YOU, I.E., HOLDING, ON APCH, ETC.  
 SYNOPSIS: ACR CAPT RPTS ARTCC CONFUSION AS ACFT ARE  
 HOLDING AT CCE FOR ARR INTO MIA. HE SUSPECTS LTSS WITH OTHER ACFT  
 THOUGHT TO BE IN THE PATTERN. SEE ACN #191235.  
 REFERENCE FACILITY ID:CCE  
 FACILITY STATE: FL  
 DISTANCE & BEARING FROM REF.: 8,,W  
 MSL ALTITUDE: 26000,26000

ACCESSION NUMBER: 217638  
DATE OF OCCURRENCE: 9208  
REPORTED BY: FLC; ; ; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TWR, LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SFO  
FACILITY STATE: CA  
FACILITY TYPE: ARPT; TWR; TWR;  
FACILITY IDENTIFIER: SFO; SFO; SFO;  
AIRCRAFT TYPE: LTT; MLG;  
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; LESS THAN LEGAL  
SEPARATION; NON ADHERENCE LEGAL RQMT/CLNC;  
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;  
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY; PROC OR  
POLICY/COMPANY;

NARRATIVE: ON AUG/SUN/92, FLT FROM SMF TO SFO WAS CLRED TO  
LAND ON RWY 28R. DURING DECELERATION, TWR CLRED US TO CROSS RWY  
28L AND CONTACT GND CTL AFTER XING. WE EXITED RWY 28R ON TAXIWAY  
'E' AND BEFORE ENTERING RWY 28L WHILE STILL INBTWN OF RWYS I  
HEARD TWR CLR AN ACFT FOR TKOF ON RWY 28L. MY REACTION WAS TO  
STOP MY ACFT BEFORE ENTERING THE RWY 28L BOUNDARY WHICH WE  
MANAGED TO DO SO. I LOOKED TO MY L AND SAW AN ACFT AT THE APCH  
END OF RWY 28L AND AT THAT POINT I DECIDED TO POSTPONE MY RWY  
XING UNTIL AFTER DEP OF THAT ACFT AND FURTHER CLRNC BY TWR. A FEW  
SECONDS LATER TWR CTLR ONCE AGAIN CLRED US FOR AN IMMEDIATE XING  
OF RWY 28L AND WITHOUT DELAY RETURNED TO DEPARTING ACFT AND  
ORDERED HIM TO ABORT HIS TKOF. AT THIS POINT, BASED ON MY  
JUDGEMENT OF HIS ROLLING SPD AND ESTIMATED OVER 6000 FT OF  
DISTANCE BTWN US, AND ASSUMING HE IS ON THE TKOF ABORTION STAGE,  
I EXECUTED AN EXPEDITIOUS XING OF RWY 28L. DURING XING I  
MAINTAINED A VISUAL CONTACT WITH THE TFC AND ENSURING THE SAFETY  
OF MY ACFT FROM THE TAKING OFF TFC WHO FAILED TO RESPOND TO  
REPEATED TKOF CANCELLATION FROM TWR. AT NO TIME DURING THIS  
ORDEAL WAS SAFETY OF MY ACFT OR PAX COMPROMISED. MY SUGGESTION  
WOULD BE MORE CAREFUL CTLRS AND MORE SITUATION AWARENESS IN TWR.  
ALSO, ON THE PART OF THE OTHER INVOLVED ACFT. TO LISTEN CLOSER TO  
ATC.

SYNOPSIS: ACR LTT PIC INDUCES A DEPARTING ACFT INTO AN  
ABORT SITUATION WHEN HE FAILS TO COMPLY WITH TWR'S CLRNC TO CROSS  
RWY 28L.

REFERENCE FACILITY ID:SFO  
FACILITY STATE: CA  
AGL ALTITUDE: 0,0

**INSTRUCTIONAL PLI ELEMENTS: Incorrect Transmission, Incorrect Action**

ACCESSION NUMBER: 109535  
DATE OF OCCURRENCE: 8904  
REPORTED BY: CTLR; ; ;  
PERSONS FUNCTIONS: TWR,LC; FLC,PLT; FLC,PLT;  
FLIGHT CONDITIONS: IMC  
REFERENCE FACILITY ID:SBA  
FACILITY STATE: CA  
FACILITY TYPE: TWR;  
FACILITY IDENTIFIER: SBA;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL  
SEPARATION; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: CTLR INTERVENED; NOT RESOLVED/INSUFFICIENT TIME;  
ANOMALY CONSEQUENCES: FAA INVESTIGATORY FOLLOW-UP;  
NARRATIVE: IFR WX, RWYS 7 AND 15L/R IN USE. SMA X WAS ON  
ILS APCH/MISSED APCH RWY 7. MISSED APCH INSTRUCTIONS WERE  
NONSTANDARD AND COORDINATED BY RADAR CTLR. RWY HDG UNTIL 700',  
THEN TURN RIGHT HDG 200 DEGS, CLB AND MAINTAIN 2000'. SMA Y  
CALLED FOR DEP IFR TO VFR ON TOP RWY 15L. RELEASE WAS OBTAINED  
FROM RADAR. SMA Y WAS GIVEN TFC (SMA X) 2 MI FINAL RWY 7 AND  
CLRED FOR TKOF RWY 15L RWY HDG CLB TO VFR ON TOP 2000'. SMA X  
EXECUTED MISSED APCH 1/2 MI FINAL, WAS INSTRUCTED TO FLY RWY HDG  
UNTIL DEP END THEN TURN TO 200 DEGS. SMA Y WAS NOW 2 MI S AT  
1300' TALKING TO DEP. SMA X BEGAN TURN TO 200 DEGS APPROX 1/2 MI  
BEYOND DEP END. SMA X TARGET WENT NO BEACON ON RADAR. RADAR CTLR  
GAVE SMA X RIGHT TURN TO 100 DEGS WHILE ACFT WAS STILL ON LCL  
FREQ. SMA Y HEARD THE HDG ISSUED THE SMA X AND TURNED LEFT TO 100  
DEGS. TARGETS PASSED WITHIN 1 1/2 MI OF EACH OTHER, ALT OF THE  
SMA X WAS UNKNOWN. LCL WAS UNABLE TO PROVIDE VIS BECAUSE OF THE  
WX. THE RADAR CTLRS RPTED THE LOSS OF SEP. THE ACFT NEVER SAW  
EACH OTHER. LCL CTLR WAS DECERTIFIED FOR THE OPERROR, NOT  
PROVIDING INITIAL SEP OF SUCCESSIVE DPTRS. LCL CTLR WAS AWARE OF  
THE SITUATION BUT JUDGEMENT WAS POOR IN ASSUMING SEP WOULD EXIST  
WHEN SMA X TURNED. POSITIVE SEP WAS NOT ENSURED.  
SYNOPSIS: ACFT TOOK HEADING INTENDED FOR ANOTHER ACFT  
AFTER DEPARTURE RESULTING IN LESS THAN STANDARD SEPARATION.  
REFERENCE FACILITY ID:SBA  
FACILITY STATE: CA  
DISTANCE & BEARING FROM REF.: 2,,SO  
MSL ALTITUDE: 0,2000

ACCESSION NUMBER: 187752  
DATE OF OCCURRENCE: 9108  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,ISTR; FLC,PLT; TWR,LC; FLC,PLT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:UGN  
FACILITY STATE: IL  
FACILITY TYPE: TWR;  
FACILITY IDENTIFIER: UGN;  
AIRCRAFT TYPE: SMA; SMA;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/FAR;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
NARRATIVE: I WAS ACTING AS FLT INSTRUCTOR IN AN SMA A.

STUDENT RECENT PRIVATE PLT TRANSITIONING FROM SMA B INVOLVED IN SHORT FIELD TKOF PROCS. COMPLETED SEVERAL TKOFS AND LNDGS, RWY 5, L TFC. LITTLE TFC IN PATTERN. MY ACFT INSTRUCTED POS AND HOLD RWY 5, DEPARTING TFC ON 14, L CLOSED TFC. TAXIED INTO POS, OTHER ACFT WAS CLRED TO TKOF AFTER SOME DELAY, ADDITIONAL DELAY WHILE TWR DEALT WITH TFC TRANSITIONING THE ATA. I WAS THEN CLRED TO TKOF. AT SOME POINT, TWR CALLED MY POS TO ANOTHER ACFT AS DEPARTING RWY 5, L CLOSED TFC. WAS UNCLR TO ME WHERE THIS OTHER ACFT WAS, POSSIBLY AN INBOUND TO THE ARPT. DISCOVERED AFTER THE INCIDENT, OTHER TFC WAS AN SMA B WHO DEPARTED 14 AND WAS TURNING ONTO DOWNWIND. I WAS UNAWARE OF THE PRESENCE OF THIS TFC. NO TA WAS ISSUED TO ME AFTER MY TKOF CLRNC. MY STUDENT FLEW A NORMAL PATTERN, TURNING XWIND, CONTINUING TO CLB TO PATTERN ALT (1500 FT), UNDERNEATH THE SMA B ON ITS DOWNWIND LEG. SMA B WAS NOT SEEN BY MYSELF OR MY STUDENT. HIGH WINGS BLOCKED VISION WHERE SMA B PROBABLY WAS PRIOR TO OUR TURN TO XWIND. WE WERE THE ONLY 2 AIRPLANES IN THE PATTERN. AS WE REACHED 1500 FT MSL, STUDENT LOWERED NOSE, RAISED L WING TO CLR TFC, AND DISCOVERED THE SMA B AT OUR ALT WITHIN 100 FT HORIZ, ABEAM OUR L WING IN STRAIGHT AND LEVEL FLT, SAME DIRECTION. I QUERIED TWR AS TO THE INTENTIONS OF THE TFC. REPLY WAS 'I CALLED OUT THAT TFC FOR YOU', REFERRING TO THE ADVISORY GIVEN WHILE I WAS STILL ON THE TAXIWAY PRIOR TO TKOF. LACKING INFO ON THE INTENTIONS OF THE SMA B I EVADED WITH A R 270 WITH TWR APPROVAL. I VISITED TWR CAB, TO GET IMPRESSION OF THE CTLR INVOLVED. HIS STATEMENTS: 1) THE ADVISORY HE GAVE ME ON THE TAXIWAY MET LEGAL REQUIREMENTS AND 'HIS ASS WAS COVERED'. 2) A PREVIOUS COMPLAINT LODGED BY ME ABOUT THE TWR WAS THE REASON FOR PROVIDING MIN ADVISORIES. 3) I WAS SUPPOSED TO BE LISTENING TO TRANSMISSIONS FROM THE TWR TO OTHERS, AND KNOW WHERE THEY WERE. 4) HE KNEW THAT I WAS ABOARD, AS AN INSTRUCTOR, AND AS THE CONFLICT DEVELOPED THOUGH MY FLT PATH WAS UNUSUAL WITH RESPECT TO THAT OF THE \_\_\_\_\_. HIS ATTITUDE WAS HOSTILE, AND THE ABOVE STATEMENTS ARE NOT INTENDED AS DIRECT QUOTES BUT ARE PARAPHRASED TO BEST OF MY RECOLLECTION. TWR CTLR WATCHED A LIFE THREATENING CONVERSION OF 2 ACFT DEVELOP, AND CHOSE NOT TO PROVIDE SEPARATION OR ADVISORIES TO ONE OF THE ACFT. THE HUMAN FACTOR INVOLVED INCLUDED THE CTLR ALLOWING A PREVIOUS COMPLAINT TO INTERFERE WITH COMMON SENSE, GOOD JUDGEMENT, CONCERN FOR SAFETY AND STANDARD PRACTICE IN THIS UNSAFE CTILING SITUATION. UNDER OTHER CONDITIONS

(REPORT CONTINUED)

AN ADVISORY WOULD HAVE BEEN ISSUED TO THE DEPARTING SMA AFTER  
THIS TKOF.

SYNOPSIS: SMA IN PATTERN HAS NMAC WITH SECOND SMA.  
REFERENCE FACILITY ID:UGN  
FACILITY STATE: IL  
DISTANCE & BEARING FROM REF.: 1  
MSL ALTITUDE: 1500,1500

## Non-Specific Party Line Incidents

ACCESSION NUMBER: 98555  
DATE OF OCCURRENCE: 8810  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; ARTCC,RDR; TRACON,AC;  
FLIGHT CONDITIONS: VMC  
FACILITY STATE: NY  
FACILITY TYPE: TRACON; ARTCC; ARPT;  
FACILITY IDENTIFIER: BUF; ZOB; IAG;  
AIRCRAFT TYPE: FGT;  
ANOMALY DESCRIPTIONS: ALT DEV/EXCURSION FROM ASSIGNED;  
ANOMALY DETECTOR: ATC/CTLR;  
ANOMALY RESOLUTION: CTLR INTERVENED; NOT RESOLVED/ANOMALY ACCEPTED;  
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;

NARRATIVE: DURING A NIGHT DESCENT INTO NIAGARA FALLS IAP, NY, MY AIRPLANE EXPERIENCED COMPLETE UTILITY HYDRAULIC FAILURE. I WAS CLEARED FROM 17000' TO 10000' AT THE TIME OF THE FAILURE, AND WAS TALKING TO CLEVELAND CENTER. I DECLARED AN EMERGENCY WITH CLEVELAND AND WAS HANDED OFF TO BUFFALO APPROACH. AFTER TALKING TO BUFFALO, I WAS CLEARED OFF THE FREQUENCY TO CONTACT OPERATION FOR ASSISTANCE. AFTER RETURNING TO APPROACH FREQUENCY, I BEGAN RUNNING CHECKLISTS, (THERE ARE AT LEAST THREE FOR THIS EMERGENCY). AT THIS POINT, I BECAME CONCERNED ABOUT FLYING IMC WITH DEGRADED FLT CONTROLS THROUGH A 5000' DECK IN THE VICINITY OF IAG, SO I ELECTED TO START A VMC DESCENT. I WAS UNABLE TO TALK TO BUFFALO APPROACH ABOUT THIS DEVIATION FROM ATC CLEARANCE BECAUSE OF CONGESTION ON THE FREQUENCY. JUST AFTER LEAVING 10000', I VISUALLY ACQUIRED AN AIRPLANE AT ABOUT 1 O'CLOCK AND SLIGHTLY LOW. I BEGAN A CLIMB BACK TO 10000', AND RECEIVED A QUERY FROM BUFFALO AND A TRAFFIC CALL ON THE 9000' TRAFFIC. HAD WE BEEN ON THE SAME FREQUENCY (UHF VS VHF), WE WOULD HAVE KNOWN ABOUT THE TRAFFIC. I THEN INFORMED BUFFALO THAT WE NEEDED AN IMMEDIATE DESCENT TO 5000', OR CLEAR OF CLOUDS. THIS WAS ACCOMPLISHED, AND AFTER BLOWING DOWN GEAR AND FLAPS, WE MADE AN UNEVENTFUL ARRESTED LANDING. AFTER FLIGHT, WE RECEIVED A CALL FROM BUFFALO APPROACH ADVISING US THAT ALTHOUGH NO TRAFFIC SEPARATION PROBLEMS OCCURRED, A REPORT WOULD BE FILED BECAUSE OF CONVERSATION ON A RECORDED LINE BETWEEN BUFFALO AND CLEVELAND. CALLBACK CONVERSATION WITH REPORTER REVEALED THE FOLLOWING: REPORTER WAS OPERATING ON UHF AND DID NOT HAVE VHF ON THE FGT. CONTROL PROBLEMS RESULTING FROM THE LOSS OF HYD WAS NO POWERED RUDDER, ONE-HALF AILERON AND SPOILER MOVEMENT. HAS RECEIVED NO FURTHER INQUIRY FROM THE FAA AND WAS ASSURED BY THE CTLR THAT NO LOSS OF SEPARATION OCCURRED. WITH THE CONTROL SITUATION HE WAS IN AND THE FACT HE COULD DESCEND IN VFR CONDITIONS, FELT THAT WAS THE BEST PROC. DID SQUAWK 7700 BUT HAD DECLARED AN EMERGENCY AND LANDED AT IAG THAT HAD AN ARRESTING GEAR.

SYNOPSIS: FGT LOST UTILITY HYDRAULIC SYSTEM RESULTING IN PARTIAL LOSS OF FLT CONTROLS AND EMERGENCY LNDG.

REFERENCE FACILITY ID:IAG

FACILITY STATE: NY

MSL ALTITUDE: 10000,17000

ACCESSION NUMBER: 100007  
DATE OF OCCURRENCE: 8812  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,PLT; FLC,PIC.CAPT; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:SBD  
FACILITY STATE: CA  
FACILITY TYPE: TWR; ARPT;  
FACILITY IDENTIFIER: SBD; LIZ;  
AIRCRAFT TYPE: SMA; MLT;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; LESS THAN LEGAL SEPARATION;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: NONE;  
NARRATIVE: MY WIFE AND I WERE DEPARTING REDLANDS MUNICIPAL  
ARPT ON A VFR FLT TO CATALINA. PRIOR TO TKOF I CONTACTED NORTON  
GND ON 121.8 AND STATED MY INTENTIONS. I WAS CLRED THROUGH  
NORTON'S ATA AND TOLD TO CONTACT NORTON TWR. I CALLED THE TWR ON  
119.45 AND WAS TOLD TO RPT WHEN AIRBORNE. WE DEPARTED AND BEGAN  
FLYING A HDG OF 240 DEGS, CLBING TO 4500' MSL. I CONTACTED NORTON  
TWR ABOUT 30 SECS AFTER TKOF. I WAS GIVEN A SQUAWK ISSUED BY  
ONTARIO APCH THROUGH NORTON TWR AND WAS TOLD TO RPT PASSING  
THROUGH 2700' MSL. ABOUT 2 MINS LATER NORTON TWR INFORMED ME THAT  
A HEAVY MLT WAS GOING TO DEPART RWY 6 FOR CLOSED RIGHT TFC. I  
RESPONDED THAT I HAD MLT Y IN SIGHT ON THE RWY. MLT Y BEGAN ITS  
TKOF AND AS SOON AS IT HAD ENOUGH ALT IT BEGAN A CLBING RIGHT  
TURN. I HAD NOT EXPECTED HIM TO TURN SO SOON AND IT BECAME  
APPARENT TO ME AT THIS TIME THAT Y AND I WERE IN IMMEDIATE  
CONFLICT. I CALLED NORTON TWR AND TOLD HIM THAT I WAS AT Y'S 1  
O'CLOCK POS. I DID NOT WAIT FOR A REPLY AND IMMEDIATELY BEGAN A  
STEEP DIVE FROM ABOUT 2500' TO AROUND 2300. ABOUT 15 SECS LATER  
MLT Y PASSED DIRECTLY OVER MY ACFT. AT NO TIME THAT I WAS ON  
NORTON'S FREQ DID I HEAR THE TWR ADVISE THE MIL PLT OF MY POS OR  
DIRECTION OF FLT. THE MLT WAS USING UHF FREQS AND I WAS ON VHF.  
THE TWR WAS USING UHF/VHF SIMULTANEOUSLY. I FEEL THIS INCIDENT  
OCCURRED BECAUSE THE TWR DID NOT ADVISE MLT Y OF MY POS AND ALSO  
BECAUSE 2 DIFFERENT FREQ BANDS WERE BEING USED. HAD Y BEEN ON  
VHF, THEY WOULD HAVE HEARD MY XMISSIONS. I FEEL THAT IN THE  
INTEREST OF SAFETY, ALL ACFT OPERATING IN CLOSE PROX UNDER ATC  
CTL BE ON THE SAME RADIO BAND AND FREQ. MANY TIMES WHILE TALKING  
TO NORTON OR ONT APCH I HAVE HEARD MIL ACFT USING VHF FREQS. IT  
MAKES IT MUCH EASIER TO UNDERSTAND THEIR INTENTIONS WHEN YOU CAN  
HEAR BOTH SIDES OF THE CONVERSATION.

SYNOPSIS: NMAC BETWEEN SMA AND MLT. OPERATIONAL ERROR BY  
MIL TWR FAC.

REFERENCE FACILITY ID:SBD  
FACILITY STATE: CA  
DISTANCE & BEARING FROM REF.: 2,,SE  
MSL ALTITUDE: 2300,2500

ACCESSION NUMBER: 123431  
DATE OF OCCURRENCE: 8909  
REPORTED BY: FLC; ;  
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,PIC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:UGN  
FACILITY STATE: IL  
FACILITY TYPE: TWR;  
FACILITY IDENTIFIER: UGN;  
AIRCRAFT TYPE: SMT; LTT;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: NONE;

NARRATIVE: FLYING OFF SHORE OVER LAKE MICHIGAN ENRTE FROM MKE TO CHICAGO CGX. VFR IN HAZY CONDITIONS (+/- 4 NM). KNOWING OUR FLT PATH WOULD TAKE US ACROSS THE UGN LOC, I ELECTED TO FLY ABOVE THE G/S ALT TO AVOID ANY INBND ACFT. AT 2700' MSL, 6 NM (REF LORAN) FROM THE ARPT, WE HAD TO MAKE A SUDDEN DEVIATION TO AVOID AN LTT INBND ON THE LOC. HE SAW US AT THE SAME TIME, AND ALSO TURNED TO AVOID A COLLISION. WE WERE MONITORING BOTH APCH AND THE CTL TWR, BUT WERE NOT TALKING TO EITHER. WE KNEW FROM MONITORING RADIOS THAT THE LTT WAS INBND, BUT ASSUMED HE WOULD BE BELOW US ON THE G/S (BELOW 2200' MSL AT THAT POINT OF THE APCH). HE WAS APPARENTLY FLYING THE LOC INBND AND MAINTAINING ALT TO CIRCLE FOR LNDG. WE MISSED THAT PART OF THE RADIO CONVERSATION, IF IT WAS INDEED WHAT TRANSPIRED. BY ASSUMING THAT HE WAS ON THE G/S, WE SET OURSELVES AND HIM UP FOR A MIDAIR. REDUCED VSBLTY MADE IT DIFFICULT TO SEE ANY ACFT THAT DAY. WE OFTEN FLY THE LAKESHORE VFR W/O COMMUNICATING WITH APCH BECAUSE OF HVY TFC AND RADIO CONGESTION IN THE CHICAGO AREA. THE SITUATION DISCOURAGES VFR ACFT FROM USING ATC FOR TFC AVOIDANCE.

SYNOPSIS: SMA HELICOPTER, IN CRUISE, CROSSES A LOCALIZER ABOVE GLIDE SLOPE, BUT HAS NMAC WITH ACR LTT INBOUND ON CIRCLE-TO-LAND.

REFERENCE FACILITY ID:UGN  
FACILITY STATE: IL  
DISTANCE & BEARING FROM REF.: 6,,N  
MSL ALTITUDE: 2700,2700

ACCESSION NUMBER: 128730  
DATE OF OCCURRENCE: 8911  
REPORTED BY: FLC; ; ; ;  
PERSONS FUNCTIONS: FLC,TRNEE; FLC,ISTR; FLC,PLT; TRACON,AC; TWR,LC;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:RNO  
FACILITY STATE: NV  
FACILITY TYPE: ARPT; TRACON; TWR;  
FACILITY IDENTIFIER: RNO; RNO; RNO;  
AIRCRAFT TYPE: SMA; ;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; OTHER;  
ANOMALY DETECTOR: COCKPIT/FLC;  
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;  
ANOMALY CONSEQUENCES: NONE;  
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;  
NARRATIVE: I WAS IN RADAR CONTACT WITH RNO ARSA AND HAD

JUST BEEN GIVEN A 090 DEG HDG TO ENTER THE RIGHT TFC PATTERN FOR 16R AT RNO. MY INSTR AND I OBSERVED TFC AT 12 O'CLOCK LESS THAN A MILE CLBING TOWARD US. I CONTINUED MY TURN AND DSNT. APCH CALLED THE TFC TO US AND WE ACKNOWLEDGED AND CONTINUED TURNING TO AVOID HIM. HE PASSED VERY CLOSE TO US AT CO-ALT BANKING TO HIS RIGHT. THE OTHER ACFT ASKED APCH WHAT WAS GOING ON, HE THOUGHT HE WAS IN RADAR CONTACT, WHY WASN'T HE AWARE OF THE CONFLICTING TFC. APCH ANSWERED HIM WITH THE RESPONSE THAT THE OTHER ACFT (ME) HAD HIM SIGHT, SO NO PROB. AFTER SPEAKING WITH TRACON AFTER LNDG, IT SEEMS TO ME THAT THE PROB WAS WITH THE HDOF FROM TWR TO APCH/DEP. WHEN WE FIRST SIGHTED THE OTHER ACFT, HE WAS STILL ON TWR FREQ, SO NEITHER ONE OF US HAD THE ADVANTAGE OF HEARING THE RADIO XMISSIONS TO EACH OTHER. THE OTHER ACFT WAS ALSO CLBING INTO THE SUN. RNO IS ALSO A TRNG FAC AND I GET THE IMPRESSION THAT THE SUPVRs AREN'T PAYING ENOUGH ATTN. THAT SAME DAY, I WITNESSED 2 OTHER INCIDENTS INVOLVING THE TWR. ONE INVOLVED AN ACFT LINED UP TO LAND ON THE TXWY. THE TWR DID NOT CATCH THE OBVIOUS UNTIL THE LNDG ACFT FLEW OVER AN ACR MLG ON THE TXWY. SHORTLY THEREAFTER, THE TWR TRIED TO TAXI THAT SAME MLG OVER US FOR TKOF. WE WERE #1 ON THE HOLD SHORT LINE FOR TKOF. TWR REQUESTED THAT WE TURN LEFT AND GET OUT OF THE WAY BECAUSE MLG HAD TO TKOF. WE HAD BEEN SITTING THERE FOR ABOUT 10-12 MINS WAITING TO TKOF WHILE THEY FIDDLLED AROUND THE LOST AIRPLANE.

SYNOPSIS: CLOSE PROX 2 GA ACFT IN RNO ARSA. REPORTER  
QUESTIONS COMPETENCE VIGILANCE OF RNO ATC TRAINING SUPVRs.

REFERENCE FACILITY ID:RNO  
FACILITY STATE: NV  
DISTANCE & BEARING FROM REF.: 5,,SE  
MSL ALTITUDE: 8000,8000

ACCESSION NUMBER: 142041  
DATE OF OCCURRENCE: 9004  
REPORTED BY: FLC; ; ;  
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; ARTCC,RDR;  
FLIGHT CONDITIONS: MXD  
REFERENCE FACILITY ID:YUL  
FACILITY STATE: PQ  
FACILITY TYPE: ARTCC;  
FACILITY IDENTIFIER: CZUL;  
AIRCRAFT TYPE: WDB;

ANOMALY DESCRIPTIONS: NO SPECIFIC ANOMALY OCCURRED;

SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;

NARRATIVE: YOU MENTIONED YOU WANTED INTL COMMENTS. BOTH IN PARTS OF CANADA AND IN FRANCE THE CTLRS REGULARLY SPEAK FRENCH TO FRENCH SPEAKING CARRIERS. THEY DO THIS IN ALL AREAS OF FLT (TAXI, TKOF, CRUISE, APCH ETC). IN BAD WX AND/OR OVERSEAS WHEN YOU ARE UNSURE OF ROUTINES, VORS, ETC, IT IS VERY DISTURBING. MUCH IS GAINED BY HEARING CLRNCS GIVEN TO OTHER ACFT, NOT ONLY IN KNOWING WHAT TO EXPECT, BUT TO BE ABLE AT TIMES TO VERIFY THAT YOU ARE PRECEDING AS YOU THOUGHT CLRED.

SYNOPSIS: U.S. ACR FO COMPLAINS OF USING FRENCH FOR ATC COMS IN PARTS OF CANADA AND FRANCE.

REFERENCE FACILITY ID:YUL

FACILITY STATE: PQ

MSL ALTITUDE: 28000,28000

ACCESSION NUMBER: 149385  
DATE OF OCCURRENCE: 9006  
REPORTED BY: OBS; ; ;  
PERSONS FUNCTIONS: MISC,OBS; FLC,PLT; FLC,PIC.CAPT;  
FLIGHT CONDITIONS: VMC  
REFERENCE FACILITY ID:STS  
FACILITY STATE: CA  
FACILITY TYPE: ARPT;  
FACILITY IDENTIFIER: STS;  
AIRCRAFT TYPE: SMA; LTT;  
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;  
ANOMALY DETECTOR: OTHER;  
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;  
ANOMALY CONSEQUENCES: NONE;  
SITUATION REPORT SUBJECTS: PHYSICAL FACILITY/ATC;

NARRATIVE: I WAS STANDING ON THE DECK OF AN ARPT FAC AND WAS TUNED INTO THE 135 KW FREQ SINCE THE CTL TWR CLOSED APPROX 15-20 MINS BEFORE. A LIGHT HIGH WINGED ACFT WAS L DOWNWIND OF SONOMA COUNTY ARPT (I BELIEVE THE CALL LETTERS, WE XRAY SOMETHING OR OTHER) THE PLT WAS CALLING OUT HIS LEGS BEAUTIFULLY AND BY THE NUMBERS. HE ANNOUNCED L DOWNWIND, TURNING R BASE AND AS HE WAS TURNING FOR FINAL FOR RWY 14 (A) COMMUTER ACFT MANUEVERED INTO POS AND ANNOUNCED IT WAS READY FOR TKOF. THE PLT OF THE LIGHT (HE HAD AN EASTERN US ACCENT) PLANE STARTED TRYING TO COM TO THE COMMUTER THAT HE WAS LNDG WITH STILL NO RESPONSE. SO IN COMPLETE FRUSTRATION THE LIGHT PLANE ANNOUNCED THAT SINCE NO RESPONSE IT WOULD GO AROUND. AT ABOUT THE POINT THAT THE LIGHT PLANE WAS OVER THE COMMUTER AT RWY 14, THE COMMUTER TAKES OF AND UP GOING INTO AND IN FRONT OF THE LIGHT PLANE. THE LIGHT PLANE PLT WAS RIGHTFULLY ANGRY AND STARTED ASKING OTHER PLTS IN THE AIR IF SAW WHAT HAPPENED (HE WAS YELLING AT THE COMMUTER). I DOUBT IF THE COMMUTER PLANE EVER SAW THE LIGHT PLANE AND CERTAINLY THEY WEREN'T (OR COULDN'T BE) ON THE SAME FREQ. WHEN I DISCUSSED THIS WITH VARIOUS FLT PERSONNEL AND INSTRUCTORS THEY SAID IT HAPPENS ALL THE TIME AND WHEN THE TWR SHUTS DOWN ITS A FREE FOR ALL. WITH THE COMMERCIAL PLTS NOT GIVING A TINKERS DAMN, THIS WAS A MAJOR DISASTER WAITING TO HAPPEN.

SYNOPSIS: CLOSE PROX COMMUTER LTT ON TKOF AND GA SMA  
MAKING A GO AROUND.

REFERENCE FACILITY ID:STS  
FACILITY STATE: CA  
AGL ALTITUDE: 0,1000

ACCESSION NUMBER: 220645  
 DATE OF OCCURRENCE: 9209  
 REPORTED BY: FLC; FLC; ; ;  
 PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC, PIC.CAPT; ARTCC, RDR;  
 ARTCC, RDR;  
 FLIGHT CONDITIONS: VMC  
 REFERENCE FACILITY ID:TPA  
 FACILITY STATE: FL  
 FACILITY TYPE: ARTCC; ARTCC;  
 FACILITY IDENTIFIER: ZMA; ZMA;  
 AIRCRAFT TYPE: MLG; MLG;  
 ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; OTHER; ALT  
 DEV/EXCURSION FROM ASSIGNED; NON ADHERENCE LEGAL RQMT/CLNC;  
 ANOMALY DETECTOR: COCKPIT/FLC; COCKPIT/EQUIPMENT;  
 ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; AUTOMATED ACFT  
 SUBSYSTEM INTERVENED;  
 ANOMALY CONSEQUENCES: FLC/ATC REVIEW;  
 NARRATIVE: CRUISING ALONG AT FL270 AND RECEIVED AN RA ON  
 THE TCASII SYS -- SOMEBODY JUST BEHIND AND CLBING -- UNTIL IT GOT  
 TO -800 WITHIN MY ALT WE CLBED. WE GOT TO ABOUT 27600 BEFORE I  
 FIGURED OUT THAT THE TARGET HAD LEVELED OFF 1000 FT BELOW US. ATC  
 DID NOT WARN US BECAUSE THAT TFC WAS CLRED TO THAT ALT BY ANOTHER  
 CTLR AND NEITHER I NOR HE WERE AWARE OF THE SITUATION. NO  
 CONFLICT OCCURRED BECAUSE OF MY COMPLIANCE WITH THE RA. THE CTLR  
 SHOULD HAVE BEEN WARNED, IT'S ALSO TOO IMPORTANT FOR ME TO LISTEN  
 TO OTHER CLRNCS TO EXPECT THESE SITUATIONS. SUPPLEMENTAL INFO  
 FROM ACN 220309: OPERATING FROM CLT-RSW UNDER CTL OF MIA CTR  
 (FREQ 127.6) SBOUND ON J75 VICINITY OF TAMPA, PF OBSERVED ANOTHER  
 ACFT ON TCASII CLBING OUT AT A LOWER ALT IN FRONT OF OUR ACFT.  
 CLBING ACFT WAS ON A RECIPROCAL COURSE AND APPEARED TO BE CLBING  
 RAPIDLY.  
 SYNOPSIS: POTENTIAL CONFLICT SENSED BY TCASII RA AND FLC  
 RESPONSE IS TO TAKE EVASIVE ACTION CLB.  
 REFERENCE FACILITY ID:TPA  
 FACILITY STATE: FL  
 MSL ALTITUDE: 27000,27600